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**A MATTER OF BALANCING: THE INABILITY TO FORCE TREATMENT
ON ALL VOLUNTARY, TREATMENT INCAPABLE PATIENTS IN
ONTARIO**

by

Cindy L. Blancher

**Submitted in partial fulfillment of the requirements
for the degree of
Master of Laws**

at

**Dalhousie University
Halifax, Nova Scotia
December, 1998**

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ABSTRACT

This thesis concentrates on the question of whether or not voluntary, treatment incapable patients who have had their treatment consented to by a substitute decision-maker can be involuntarily treated. It is my opinion that under the current legislative scheme in Ontario the restraint of a voluntary, treatment incapable patient for the purposes of treatment is illegal subject to the following exceptions:

- a) a guardianship order exists that contains authority to restrain and detain; or**
- b) a Power of Attorney for Personal Care has been executed by the now treatment incapable individual authorizing his substitute decision-maker to have him detained and restrained for the purposes of treatment.**

While some have suggested legislative reform to alleviate the possibility of this situation occurring, I do not endorse this suggestion. Instead, the use of advance directives should be encouraged, as well as the education of the person with the mental illness, family members, friends, health care providers, the legal community and members of the Consent and Capacity Board regarding the powers and limitations of the current legislative scheme.

ABBREVIATIONS

POAPC	power of attorney for personal care
SDM	substitute decision-maker

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INTRODUCTION

In the mid 19th century, the law in Ontario permitted the detention of persons in asylums on the basis that they were deemed to be “lunatics.” Once admitted to an asylum, treatment was given. In general, in the Ontario of years past, once diagnosed as a person with mental illness, treatment was automatically administered. Such “treatment” often consisted of extremely invasive procedures that are considered today as acts of abuse.¹

Over time, however, it was acknowledged that the state required more justification to deny the freedom of persons with mental illnesses. This resulted in a narrowing of the commitment criteria.² In addition, the mere fact that one was a patient in a psychiatric facility, or even an involuntary patient, no longer automatically authorized the imposition of treatment--consent was required.³

Incremental changes have included increased procedural protections⁴ and the acknowledgment that competent patients have the right to make decisions

¹For examples such as surgical interventions, forced emetics, and depatterning, see Chapter 1.

²The criteria was narrowed in the Mental Hospitals Act, S.O. 1950, c. 229, s. 20. See p. 8.

³See Chapter 2, pages 80-83.

⁴Ontario instituted review boards in the Mental Health Act, 1967, S.O. 1967, c. 51 and patient's rights advice with the introduction of the Psychiatric Patient Advocate's Office in 1982.

regarding treatment, including the refusal of treatment.⁵ Legislation was also introduced to put in place a system whereby a substitute decision-maker may be authorized to consent to treatment on behalf of an incapable person.⁶

From grave abuses of the past, the approach towards the mentally ill has swung like a pendulum to a sharp focus on the “rights” of persons with mental illnesses. Many groups and individuals have expressed dissatisfaction with the current Ontario legislation, stating it is too liberal, preventing the detention and treatment of persons with mental illnesses, with detrimental consequences to the patient and increased danger to society.⁷ In particular, many people feel that hospitals are prohibited from forcing treatment on voluntary patients who are incapable of making treatment decisions even when substitute decision-makers believe treatment to be in the best interest of the patient. They propose that the current

⁵See p. 80-83.

⁶Ibid.

⁷Timothy Appelby and Jill Mahoney, “Fear Underground: Coping with Subway Shovings” The Globe and Mail (7 February 1998) A1; Michael Valpy, “Mental Illness: Cleaning out the Cuckoo’s Nest” The Globe and Mail (7 March 1998) D1; David Frum, “Report on Mentally Ill Lacks Recommendations” The London Free Press (13 June 1998); Jim Morris, “Take Mentally Ill off Street, Jury Urges” The Globe and Mail (26 November 1997) A12; Rory Leishman, “Cease Abandoning Mentally Ill” The London Free Press (4 May 1998) C1.

legislative scheme in Ontario does not permit forced treatment of all voluntary,⁸ treatment incapable⁹ patients who refuses to take medication orally, or to comply with procedures such as electroconvulsive therapy, even when the appropriate substitute decision-maker has provided consent.¹⁰ They believe this to be evidence of a system of legislation in need of reform.

In this thesis I will center on the questions of whether:

- a) the forced treatment of voluntary, treatment incapable patients is prohibited under Ontario law; and, if so,
- b) whether it should be.

I will first present a review of the history of commitment and treatment of persons with mental illnesses in Ontario since the 19th century. The medical procedures and/or medications employed by psychiatrists during this period will also be highlighted. Such a review serves as a cautionary backdrop against which current approaches to the care of persons with mental illness should be assessed.

I will then provide a thorough review of the current Ontario law. In Chapter 2, I

⁸“Voluntary” means essentially that the person must be discharged on his or her request. See Chapter 2, p. 36-38.

⁹A person is treatment incapable if he or she cannot understand or appreciate the consequences of giving or refusing consent. See Chapter 2, p. 67-68.

¹⁰See Chapter 2, p. 92.

outline the mental health legislation in Ontario regarding hospitalization and treatment that is contained in the Mental Health Act,¹¹ the Substitute Decisions Act, 1992,¹² and the Health Care Consent Act, 1996.¹³ Through this Chapter I will demonstrate that, under Ontario law, health care providers are prevented from forcing treatment on voluntary patients who are not capable of making treatment decisions.¹⁴

In Chapter 3, I will present ethical and policy considerations in relation to the current Ontario law. Particularly, what are the arguments for and against the involuntary treatment of voluntary, treatment incapable patients who refuse to comply with treatment that has been consented to by their substitute decision-maker? While there are compelling arguments on both sides I believe that a contextual review will demonstrate such treatment cannot be justified.

Finally, despite recognizing that the current legislative scheme is not without

¹¹R.S.O. 1990, c. M.7.

¹²S.O. 1992, c. 30.

¹³S.O. 1996, c. 2, Sch. A.

¹⁴With the exception that some voluntary, treatment incapable patients may be involuntarily treated when appropriate authority is in place through a guardianship order, or Power of Attorney for Personal Care. These exceptions will be further expanded in Chapter 2.

shortcomings, in Chapter 4 I will argue that the legislation should not be reformed. I will review and dismiss suggestions to broaden the commitment criteria, to increase power to the substitute decision-maker, and/or to mandate that all voluntary patients be competent to consent to treatment and admission. I will also dismiss suggestions that application could be made to the court under its parens patriae jurisdiction. I will then review and accept suggestions to encourage the use of advance directives, and to educate health care providers, family and friends, the legal community, and members of the Consent and Capacity Board regarding the current legislative scheme that attempts to balance competing societal and individual rights.

CHAPTER 1--HISTORY

Introduction

In this chapter, I will briefly review the historical treatment of the mentally ill in Ontario over the past two centuries. This review will focus on the law regarding commitment, the law regarding consent to treatment, and practice (as illuminated by descriptions of procedures used in the treatment of mental illness).

I believe that it is instructive to review this history of persons with mental illnesses in Ontario to provide a backdrop against which any proposed changes to the current legislation can be reviewed. Such a review will be instructive regarding the nature of the legislation, and it will also provide insight into the nature of discrimination that persons with mental illnesses have faced in the past. Any consideration of changes to the current legislation must ensure that similar injustices will not be repeated.

I. Review of the Law Regarding Commitment

The treatment of those persons with mental illnesses in Ontario during the late 19th and early 20th century was similar to that in England and the United States. The rich mentally ill were cared for at home or discreetly placed in private asylums in

order to protect the reputation of the family.¹⁵ The poor mentally ill often became the responsibility of the community: a local family was often paid to care for such individuals, but if the cost became prohibitive, the person was often driven from the community. Many eventually became residents of the “poor house”. However, because of problems with overcrowding, the mentally ill began to be placed apart from the poor in asylums under the County Asylums Act, 1817.¹⁶ In order to prevent overcrowding and taxing the public purse, rules were established regarding who could be granted admission: thus, the issue of committal arose.

The law regarding committal of persons with mental illnesses has centered around two major issues: first, the basis for committal, and second, the power to commit. Persons were committed to asylums simply because they had been diagnosed as “lunatics”. An Act Respecting Asylums for the Insane, 1870-71,¹⁷ authorized the involuntary detention of a person by way of a medical certificate signed by three

¹⁵Warren Thomas Reich, ed. Encyclopedia of Bioethics (revised edition) (Toronto: Simon and Schuster and Prentice Hall International, 1995) at 1927-28.

¹⁶Michael Bay, “The Ontario Mental Health Act” (1997) 17:4 Health Law in Canada 124. Bay relates that the reason the mentally ill were separated from the poor was that they began to fill the poor houses. As a control measure, the admission to the new asylums required an order of the justice of the peace.

¹⁷S.O. 1870-71, c. 18.

physicians. The Act provided that:

6. Such certificate shall state that the inspecting medical practitioners at the same time, and in the presence of each other, examined the patient, and after due enquiry into all necessary facts relating to his case, found him to be a lunatic.

7. Such certificate shall be sufficient authority to any person to convey the lunatic to any of the said Asylums, and to the authorities thereof to detain him therein so long as he continues to be insane.¹⁸

Involuntary committal as a result of being diagnosed as a “lunatic” continued until 1950, when the legislation was revised such that, to be admitted into a psychiatric facility, a person had to have a mental illness and “...requires care, supervision and control for his own protection or welfare, or for the protection of others.”¹⁹

By 1877 the Ontario statute regarding “Lunatic Asylums and the Custody of Insane Persons”²⁰ provided two routes of admission to an asylum. The highlights of each avenue are as follows:

¹⁸S.O. 1870-71, c. 18, ss. 6 and 7.

¹⁹Mental Hospitals Act, S.O. 1950, c. 229, s. 20 (2) (m). It should be noted that the legislation from the 1870s to the 1950s changed little in substance regarding admission to an asylum and the route by which admission was granted.

²⁰An Act Respecting Lunatic Asylums and the Custody of Insane Persons, R.S.O. 1877, c. 220.

Route 1--Medical Certificate	Route 2--Lieutenant Governor's Warrant
<ul style="list-style-type: none"> -required signature of 3 doctors²¹ -criterion for admission: person was a lunatic²² -superintendent had to approve both the admission and discharge of any person admitted by way of a medical certificate²³ 	<ul style="list-style-type: none"> -information given to a Justice of the Peace that indicated the person was "...insane and dangerous to be at large..."²⁴ -the Justice of the Peace could issue a warrant to have the person conducted to jail²⁵ -the jail surgeon and another doctor could issue a medical certificate²⁶ -a county Judge would also have to issue an order of committal²⁷ -all above subject to the approval of the Department of the Provincial Secretary²⁸ -once approved, a warrant was issued to conduct the person from the jail to the asylum²⁹

²¹An Act Respecting Lunatic Asylums and the Custody of Insane Persons, R.S.O. 1877, c. 220, s. 8.

²²Ibid.

²³Ibid.

²⁴Ibid.

²⁵Ibid. at s. 17.

²⁶Ibid. at s. 30.

²⁷Ibid.

²⁸Ibid.

²⁹Ibid. Note: for additional explanation regarding the provisions of this Act, see S.E.D. Shortt, Victorian Lunacy (Richard M. Bucke and the Practice of Late Nineteenth-Century Psychiatry) (Cambridge: Cambridge University Press, 1986) at 51.

By 1935³⁰ the power to commit was placed entirely within the domain of physicians: no aspect required the approval of a member of the judiciary.³¹

The revised process of committal was criticized as offering few protections to those persons wrongfully detained. In 1938 after a lawyer acquaintance of Premier Mitchell Hepburn complained to him that he had been imprisoned at London Psychiatric Hospital for three years, despite the fact that he alleged he had not been suffering from a mental disorder, an inquiry was established.³² A series of recommendations, including the introduction of regular boards of review to monitor patients' detentions, was made.³³ Few of the recommendations were

³⁰Mental Hospitals Act, 1935, S.O. 1935, c. 39. The precise reasons for the change to the commitment procedures is not entirely clear to me as a person who is not a historian, but the 1930s were a time of much change surrounding mental health in Ontario. These changes included:

- a) an increased push for out patient treatment centres. In 1930/31 the Department of Health opened six clinics in Ontario but these were soon abandoned as unworkable (e.g. much of the staff's time was spent administering I.Q. tests to single mothers because a popular belief of the day equated motherhood outside of marriage to mental retardation);
- b) the introduction of Approved Boarding Homes (in 1933);
- c) reform on the commitment procedures; and
- d) the belief that mental illness was a disease just like other medical illnesses and therefore, subject to cure. Many new treatments, developed in Europe, encouraged psychiatrists to push for changes to legitimize their profession.

See Harvey G. Simmons, Unbalanced: Mental Health Policy in Ontario 1930-1989 (Toronto Wall and Thompson, 1990) at ix and 47-49.

³¹Bay, supra note 16 at 124.

³²Simmons, supra note 30 at 9.

³³ibid. at 10.

implemented: indeed it was not until 1967 that review boards were established in Ontario.

Criticisms of the Mental Health Act in Ontario continued. In the mid 1960s, a farmer on the Bruce Peninsula drove a tax collector off his property with a shotgun.³⁴ The man was committed to the Penetanguishene Mental Hospital but hired a lawyer and spoke in the press of his treatment.³⁵ After an application was made for *habeas corpus*, a judge appointed a board to review the situation.³⁶ Although the board never met because the farmer was discharged the day prior to the meeting, the episode led to the passage of Ontario's first Mental Health Act.³⁷

The Mental Health Act, 1967 statutorily provided for review boards³⁸ and more

³⁴Bay, supra note 16 at 124.

³⁵Ibid.

³⁶Ibid.

³⁷Ibid. It should be noted that Ontario did have a previous Act entitled the "Mental Health Act" (S.O. 1954, c. 50). That Act was purely an administrative directive as set out in s. 2 for the Minister and department officials to "...promote and encourage the establishment and co-ordination of facilities for the accumulation and dissemination of information relating to mental health, and advise and assist local boards, medical officers of health, public hospitals and other persons and institutions in all matters pertaining to mental health."

³⁸Mental Health Act, 1967, S.O. 1967, c. 51, s. 28.

stringent criteria for involuntary commitment than had been in place in the past.³⁹

S. 8 of the Act incorporated a dangerousness-oriented criterion:

8.--(1) Any person who,
 (a) suffers from mental disorder of a nature or degree
 so as to require hospitalization in the interests of his
 own safety or the safety of others; and

(b) is not suitable for admission as an informal patient,

may be admitted as an involuntary patient to a psychiatric
 facility upon application therefore in the prescribed form
 signed by a physician.⁴⁰

The Mental Health Act has been amended in 1978, 1986, 1987, 1992 and 1996

(with the creation of the Health Care Consent Act, 1996⁴¹).⁴² These amended Acts
 reflect the continued focus on the need for procedural protections for persons with

³⁹Mental Health Act, 1967, S.O. 1967, c. 51, s. 8. See also Bay, supra note 16 at 124.

⁴⁰It should be noted that the number of physicians required to commit a person to a psychiatric facility has decreased steadily throughout the years. For example, the Provincial Lunatic Asylum Act, S.O. 1853 (16 V.) c. 188, s. 7; An Act Respecting Asylums for the Insane, S.O. 1870-71, c. 18, s. 5; and An Act Respecting Lunatic Asylums and the Custody of Insane Persons, R.S.O. 1877, c. 220, s. 8, all required the signature of 3 physicians for committal. By 1887, however, only 2 physicians were required to provide certificates for committal: see An Act Respecting Lunatic Asylums and the Custody of Insane Persons, R.S.O. 1887, c. 245, s. 7; Hospitals for the Insane Act, R.S.O. 1914, c. 295, s. 7; and the Mental Hospitals Act, S.O. 1950, c. 229, s. 20 (1). The Mental Health Act, 1967, S.O. 1967, c. 51, s. 8 (1) required only one physician to complete a certificate that resulted in involuntary commitment and this requirement continues today; see the Mental Health Act, R.S.O. 1990, c. M.7, s. 1.

⁴¹S.O. 1996, c. 2, Sch. A.

⁴²Bay, supra note 16 at 124. The current state of the law, as outlined in the 1996 amendments, will be discussed more fully in Chapter 2.

mental illnesses, as well as the conflict between balancing the rights of such persons with the duty to provide care.⁴³

II. Review of the Law Regarding Consent to Treatment

Persons with mental illnesses were often deemed to have no ability to make decisions of any kind for themselves: the mere presence of mental illness correlated to a finding of incapacity to make any decisions. As Dr. C. A. Roberts explained:

It didn't occur to me with a certified patient, any more than with a prisoner, that there was any question of asking them whether or not they wanted treatment. They had been brought to hospital mentally ill, incapable of judgment or decision, so they were treated. That was true of mental hospitals, prisons, homes for the aged, and county homes. Formalized consents were a postwar development.⁴⁴

Since it did not occur to many physicians that persons with mental illness could make decisions regarding their care, who provided consent? In keeping with the belief that the physician knew best what was appropriate for his or her patients, traditionally, the superintendent of the provincial psychiatric hospitals assumed much of the decision-making capacity for all the patients in the institution:

The superintendent ruled supreme within the hospital, the patients were his subjects and however kindly an individual superintendent

⁴³The conflict between liberty and beneficence will be discussed more fully in Chapter 3.

⁴⁴Simmons, *supra* note 30 at 225.

might feel toward these subjects they were, ultimately at his mercy and the mercy of the hospital staff. By claiming they were acting in the patients' best interests, psychiatrists could solemnly invoke intrusive and cruel treatments without anyone raising an eyebrow.⁴⁵

The loss of control over one's body and other rights by virtue of being an involuntarily hospitalized person, diagnosed with a mental illness, was extensive.

As Simmons points out:

Once in hospital the patient was virtually a prisoner, with the superintendent granted "full control over the custody and care of the person of every patient" in the institution. This meant that patients could be forcibly subjected to an array of drastic treatments such as insulin coma therapy, metrazol, electroshock, wet packs and even, as we have seen, psychosurgery. Patients could lose control of their property, they were stripped of their right to vote in provincial and federal elections, barred from practicing as funeral directors, police officers, accountants, medical doctors, pharmacists and they could be deported from the province or even Canada.⁴⁶

When some persons in the system began questioning the propriety of treating patients without any consent *per se*, many superintendents asked the Department of Health to require relatives to provide the superintendents with "blanket consent for any treatment which may, in our judgment, be of benefit to the patient."⁴⁷ Other superintendents asked permission of the Department of Health to send out consent forms to relatives of those patients who they wished to provide with various

⁴⁵Simmons, *supra* note 30 at 23.

⁴⁶*Ibid.* at 226.

⁴⁷*Ibid.* at 25.

treatments. The Department, and some psychiatrists, were not in favour of such a practice: “When any patient comes to us for psychiatric treatment we should not be interfered with in giving adequate treatment by the withholding of consent by relatives.”⁴⁸

There was no explicit reference to the treatment (voluntary or involuntary) of patients in psychiatric facilities in the statutes of Ontario until the Mental Hospitals Act, 1935.⁴⁹ S. 15 stated:

Except as provided by this Act, the superintendent of an institution shall have full control over and the custody and care of the person of every patient in the institution and every patient shall be maintained, cared for, treated in, released and discharged therefrom only as may be provided by this Act and the regulations. [emphasis added]

Over time there were some transitions in the law regarding treatment, but the approach remained the same. The Mental Incompetency Act, 1960⁵⁰ applied in conjunction with the Mental Hospitals Act regarding the care of persons who were incapable to consent to treatment. The Mental Incompetency Act stated:

2.--(1) Subject to *The Mental Hospitals Act*, the court has all the powers, jurisdiction and authority of Her Majesty over and in relation to the persons and estates of mentally

⁴⁸Simmons, supra note 30 at 23, quoting Dr. Stevenson.

⁴⁹S.O. 1935, c. 39.

⁵⁰R.S.O. 1960, c. 237.

incompetent persons, including the care and the commitment of the custody of mentally incompetent persons and of their persons and estates.

(2) The court may make orders for the custody of mentally incompetent persons and the management of their estates, and every such order takes effect, as to the custody of the person, immediately and, as to the custody of the estate, upon the completion of the committee's security. R.S.O. 1950, c. 230, s. 2.⁵¹

When physicians became aware of the need for some type of authority or consent to treat individuals, many believed that the Public Hospitals Act⁵² and its 1952 regulations provided that authority.⁵³ However, as Hoffman points out:

[n]ot only was the definition of competency lacking but also there was not legal coverage at all for treatment in the community or for

⁵¹Mental Incompetency Act, R.S.O. 1960, c. 237, s. 2 (1) and (2).

⁵²R.S.O. 1950, c. 307.

⁵³Brian F. Hoffman, The Law of Consent to Treatment in Ontario, (Toronto: Butterworths, 1995) at 105 and Ontario, "Enquiry on Mental Competency: Final Report" (Chairman David N. Weisstub) (Toronto: Queen's Printer, 1990) at 308. O. Reg. 216/52, s. 43 stated:

- No surgical operation shall be performed on a patient unless a consent in writing for the performance of the operation has been signed by the
- (a) patient,
 - (b) spouse, one of the next of kin or parent of the patient if the patient is unable to by reason of mental or physical disability, or
 - (c) parent or guardian of the patient if the patient is unmarried and under 18 years of age
- but if the surgeon believes that delay caused by obtaining consent would endanger the life of the patient
- (d) the consent shall not be necessary, and
 - (e) the surgeon shall write and sign a statement that a delay would endanger the life of the patient.

decisions about other areas of personal care; thus, in these laws, standards of competency or capacity assessments, guide-lines for substitute decisions, hierarchy of decision makers, rights or review and legal appeal were generally lacking.⁵⁴

The Mental Hospitals Act⁵⁵ of 1950 set out the powers of the superintendent of a psychiatric facility to include the

full control over, and the custody and care of the person of every patient in the institution and every patient shall be maintained, cared for, treated in, released and discharged therefrom only as may be provided by this Act and the regulations.⁵⁶

However, the Mental Health Act, 1967⁵⁷ spoke in more restrictive terms and separated the areas of involuntary commitment from the need for treatment.⁵⁸

The criterion for involuntary committal was narrowed to the dangerousness standard⁵⁹ and there was no mention of “control over” or treatment as there was in the 1950 legislation. The change in legislation did not, however, result in a change in the practice of all psychiatrists treating patients without consent.⁶⁰

⁵⁴Hoffman, supra note 53 at 105.

⁵⁵S.O. 1950, c. 229.

⁵⁶S.O. 1950, c. 229, s. 14.

⁵⁷S.O. 1967, c. 51.

⁵⁸Hoffman, supra note 53 at 106.

⁵⁹Ibid.

⁶⁰Simmons, supra note 30 at 228-30.

With the increased movement to patient's rights that began in the 1960s and 1970s, the potential for persons with mental illness to have their civil rights violated was highlighted.⁶¹ The increased focus on rights in general resulted in incremental legislative acknowledgments of the rights of persons with mental illnesses to make decisions regarding accepting or refusing treatment. By 1980 the Ontario Mental Health Act⁶² acknowledged that capable patients had a right to refuse treatment⁶³ and provided a mechanism for a person to appoint a substitute decision-maker to act on her competent wishes in the event of future incapacity.⁶⁴ The Act, however, also empowered a Review Board to override the wishes of an involuntary, treatment incapable patient who had made prior wishes while capable.⁶⁵

⁶¹The Canadian Civil Liberties Association commissioned two lawyers to review a sample of 200 involuntary certificates in the mid 1970s. They concluded that approximately "80% of the commitments were legally insufficient, lacking completeness, adequacy and noncircularity of evidence". See: Stewart Page "Commitment of the Mentally Ill in Ontario: The Last Two Decades" (1994) 18:3 4 Legal Medical Quarterly 9.

⁶²Mental Health Act, R. S.O. 1980, c. 262.

⁶³Mental Health Act, R.S.O. 1980, c. 262, s. 35 (2) (a).

⁶⁴Mental Health Act, R.S.O. 1980, c. 262, s. 1b.

⁶⁵Mental Health Act, R.S.O. 1980, c. 262, s. 35a (4). This section was ruled unconstitutional in Fleming v. Reid (1991), 4 O.R. (3d) 74, 82 D.L.R. (4th) 298 (C.A.) (hereinafter Fleming) which will be discussed further in Chapter 2.

III. Early Procedures Used to Treat Persons with Mental Illnesses

As outlined above, in the years past, patients were involuntarily committed and treated without consent in Ontario. However, family members, persons from the general public, and even some professionals began to question the practice of the day. What was happening to these people? Did they need more protection? In order to understand why people became so concerned regarding the treatment of the mentally ill in Ontario at that time, I will now provide a review of some of the treatments to which persons with mental illness were subjected.

A) Sustained Sleep

Persons with psychiatric illness, particularly those with psychotic or manic symptoms, were given drugs to induce prolonged periods of sleep. Dr. Neil Macleod, a doctor from Scotland, placed a 50 year old woman experiencing delusions into a bromide-induced sleep that lasted over twelve days.⁶⁶ Macleod treated other patients with prolonged sleep and claimed that, upon awakening, their illnesses had disappeared.⁶⁷

⁶⁶Shorter, Edward, A History of Psychiatry (New York: John Wiley & Sons Ltd., 1997,) at 202.

⁶⁷Ibid.

Induced sleep by bromide administration was soon abandoned by other doctors,⁶⁸ but the use of barbiturates to induce prolonged sleep was introduced. Some patients died following this procedure,⁶⁹ but attempts to discover safer barbiturates continued. A particularly dark chapter in Canadian medical history surrounded the use of barbiturate-induced sleep by Dr. D. Ewen Cameron in Montreal.

Dr. Cameron placed persons in a deep sleep and then performed other procedures upon them.⁷⁰ Although Dr. Cameron died “essentially in disgrace”⁷¹ in 1964, he had been a highly respected member of the psychiatric community. He won several awards and had been a president of the American Psychiatric Association and the World Psychiatric Association.⁷²

B) Insulin Coma

The use of “Insulin Coma Therapy” began in Ontario on May 31, 1937 at the Toronto Psychiatric Hospital.⁷⁴ It was described by a Department of Health

⁶⁸Shorter, supra note 66 at 202. This treatment may have been abandoned because of the risk of bromide toxicity.

⁶⁹Ibid. at 205. Swiss psychiatrist Max Müller determined that sleep induced treatment using the barbiturate Somnifen had a mortality rate of approximately 5%.

⁷⁰See section on “depatterning” on p. 26.

⁷¹Shorter, supra note 66 at 207.

⁷²CBC, The Fifth Estate, Jan. 6, 1998.

⁷⁴Simmons, supra note 30 at 16.

Official as “...a unique experiment...at present limited to females”.⁷⁵ In the case of insulin coma therapy, patients were given large doses of insulin, a substance normally produced in the body in the pancreas to regulate sugars in the body. In psychiatric facilities, persons with no physiological indication for treatment with insulin were given massive dosages of the drug. Patients were in fact placed in an insulin coma, a condition that is today avoided at all costs in the treatment of persons with diabetes because of the profound dangers and harm done to the body by such a state. After being placed in an insulin coma, the patients were subsequently given glucose. Following a series of insulin-induced comas⁷⁶ some of the patients had periods of lucidity for various durations.⁷⁷ Dr. Peter Breggin, described his encounter with insulin shock during his training:

⁷⁵Simmons, supra note 30 at 16. It is disturbing to note that many of these very intrusive procedures were performed first, or disproportionately, upon women. In addition to the example of insulin coma cited above, electro-convulsive therapy was administered much more frequently to women than to men. For example, in 1964, at Whitby Psychiatric Hospital, 2,175 women were given ECT compared to 884 men (see Simmons, supra note 30 at 19/20). It is also disturbing that Dr. R. M. Bucke performed gynecological surgery on 209 women before abandoning the practice, while only wiring the foreskins of 15 men before ceasing that “treatment”: see page 31-32 for more details regarding Dr. Bucke. Lobotomies were also performed on women far more frequently than on men (see note #105). While a full discussion of this point is beyond the scope of this thesis, it should be noted that the disproportionate numbers of harmful treatments inflicted on women is another example of the male-dominated discrimination women have endured in the past.

⁷⁶Some patients were placed in insulin comas approximately 20 times, while in Nova Scotia in 1943, Dr. Charles Roberts increased his patients’ insulin dosages over a period of 10 days that would result in a deep coma: See Shorter, supra note 66 at 212-213.

⁷⁷Ibid. at 213.

I observed the insulin coma room, where rows of patients were purposely overdosed with insulin, causing a drop in their blood sugar, until they fell into convulsions and a coma from starvation of the brain. As I watched them writhe about on mats, near death, it seemed like a scene from hell. I watched them being fed sugar and orange juice, to awaken into a state of fear and confusion. The once difficult and unruly inmates with their brains now permanently damaged, became gratefully dependent on their keepers after being brought back from the edge of death. Their righteous physicians called it an improvement and even a cure.⁷⁸

C) Metrazol Therapy

Metrazol is a camphor-based drug that was used beginning in the 1930s on persons in psychiatric hospitals.⁷⁹ This drug produced “spine-cracking convulsions”⁸⁰ which some claimed resulted in relief of some psychotic symptoms for some patients.⁸¹ Metrazol (and its successor Cardiazol) produced convulsions that resulted in a number of spinal fractures.⁸² In addition, the drugs did not always produce the desired convulsions, and resulted in vomiting and muscular discomfort in the injection site post procedure.⁸³ Many patients did not want to be injected

⁷⁸Peter R. Breggin Toxic Psychiatry (New York: St. Martin’s Press, 1991) at 6.

⁷⁹Simmons, supra note 30 at 15.

⁸⁰Ibid.

⁸¹Shorter, supra note 66 at 215-216.

⁸²Simmons, supra note 30 at 19-20.

⁸³Shorter, supra note 66 at 216.

with these drugs because of the severe feelings of dread and anxiety they experienced prior to convulsing.⁸⁴ In fact, one psychiatrist responsible for administering a camphor treatment in England recalled “...the unseemly and tragic farce of an unwilling patient being pursued by a posse of nurses with me, a fully loaded syringe in my hand, bringing up the rear.”⁸⁵ The introduction of electroconvulsive therapy resulted in the termination of camphor treatments.⁸⁶

D) Laxatives

“Administering laxatives to the mentally ill on the assumption that toxins bottled up in the colon were making them insane, reached back to the Middle Ages and before.”⁸⁷ The belief that cleansing the bowel with harsh laxatives could shorten an episode of mental illness continued until the 1920s.⁸⁸

E) Forced Emetics

Various drugs that produced violent vomiting were also used to treat persons with manic symptoms during the middle 19th century:

⁸⁴Shorter, supra note 66 at 216.

⁸⁵Ibid.

⁸⁶ECT to be explained further: see page 24.

⁸⁷Shorter, supra note 66 at 196.

⁸⁸Ibid.

...patients who were bothered by mania and could not slow down were administered this drug [Apomorphine]. They were said to literally turn green and vomit for up to an hour. This would have a sapping effect and they would finally be able to get six hours or so of much needed rest.⁸⁹

F) Electroconvulsive Therapy

Of all the treatments described above, electroconvulsive therapy, or ECT, is the only one still used in modern day psychiatry, although with much less frequency, and with much different administration than in the past. ECT came into favour after experiments revealed that it was a much safer way to induce seizures than metrazol therapy. The risks of spinal fracture were reduced,⁹⁰ patients were more receptive to it than metrazol, and it was much cheaper and easier to administer.⁹¹

The use of ECT as therapy for mental illness began in 1941 in Ontario.⁹² As the

⁸⁹Shorter, supra note 66 at 196.

⁹⁰Simmons, supra note 30 at 19-20. Simmons also points out that the initial indications that ECT produced negligible instances of spinal fractures were dispelled by 1950 when statistics revealed that between 1944 and 1950, 12.8% of persons receiving ECT suffered compression fractures of the spine.

⁹¹Ibid.

⁹²Ibid.

following statistics reveal, it rapidly gained popularity with psychiatrists:

<u>Year(s)</u>	<u>Number of ECT Performed in Ontario</u>
1941--1945	2,003
by 1950	9,480
by 1964	24,652 ⁹³

It is unclear, even today, how ECT expressly works to alleviate some symptoms of mental illness, particularly depression.⁹⁴ In the early days of administration in Ontario it was acknowledged that ECT served to subdue some violent patients and made caring for them much easier: a reference from the Archives of Ontario revealed that “[s]hock therapy also greatly eased the nursing problem”.⁹⁵ Dr. N. L. Easton, in 1946 advised the director of the hospitals division that he believed ECT should be used on the wards “...with the purpose of treating chronically disturbed patients...the nursing problem would be greatly alleviated and the destruction almost eliminated.”⁹⁶

Electroconvulsive therapy is still performed today, particularly for treatment of

⁹³Simmons, supra note 30 at 19-20.

⁹⁴Shorter, supra note 66 at 207-8.

⁹⁵Simmons, supra note 30 at 21.

⁹⁶Ibid.

major, irretractable depression. However, its use was sharply curtailed following the anti-psychiatry movement that began in the 1960s.

G) “Depatterning”

Dr. Ewen Cameron,⁹⁷ the renowned psychiatrist who practiced in Montreal, instituted a procedure he called “depatterning” with the aim of changing the person’s previous behaviour.⁹⁸ To achieve this end he placed his patients in prolonged sleep and then attempted to erase and replace the images in their minds. He did this by the use of continuous drug-induced sleep, ECT, and repeated taped messages. As noted earlier, Dr. Cameron died in 1964, “essentially in disgrace.”⁹⁹ Subsequently it has been revealed that Dr. Cameron was receiving funds from both the CIA and the Canadian government to conduct these experiments regarding what we commonly refer to as brainwashing.¹⁰⁰

H) Psychosurgery

The concept of performing surgery on the brain to alleviate mental illness dates

⁹⁷See section on “sustained sleep”, p. 19.

⁹⁸Shorter, supra note 66 at 207.

⁹⁹See p. 20.

¹⁰⁰The legacy of Dr. Cameron has been detailed in several different media, including the CBC Fifth Estate television show of Jan. 6, 1998.

back to the Middle Ages when doctors “fantasized about cutting for the mythical ‘stone of madness’”.¹⁰¹ The most famous modern day re-creation of psychosurgery was portrayed in the film “One Flew Over the Cuckoo’s Nest.” In this film, the lead character, refusing to adhere to hospital and societal norms, was lobotomized.

Psychosurgery refers to any surgery involving the brain. Lobotomies are procedures most commonly associated with attempts at psychiatric treatment. Pre-frontal lobotomies were performed either by drilling holes in the skull and inserting an instrument to sever the nerve pathways or by inserting an icepick through the eye socket and thin bone to reach the frontal lobes.¹⁰² Surgical interference with the brain’s frontal lobes has far reaching consequences:

The frontal lobes are the seat of higher human functions, such as love, concern for others, empathy, self-insight, creativity, initiative, autonomy, rationality, abstract reasoning, judgment, future planning, foresight, willpower, determination, and concentration. The frontal lobes allow us to be ‘human’ in the full sense of that word; they are required for a civilized, effective, mature life.¹⁰³

Such procedures gained prominence in Ontario in the 1940s. The first lobotomy

¹⁰¹Shorter, *supra* note 66 at 225.

¹⁰²The New Encyclopedia Britannica, 1997 ed., s.v. “Lobotomy”.

¹⁰³Breggin, *supra* note 78 at 53.

operations were performed in Ontario at the Toronto Psychiatric Hospital in 1944¹⁰⁴ and were performed disproportionately on women.¹⁰⁵ In total, “[b]etween 1944 and 1967 approximately 1,000 lobotomies were done at various provincial mental hospitals. An unknown number of operations were performed in general hospitals on patients admitted from the community and at the federally run Westminister Veteran’s Hospital in London, Ontario.”¹⁰⁶

In the United States, Dr. Walter Freeman became the major promoter of lobotomies. He claimed to have performed 5,000 lobotomies¹⁰⁷ and travelled throughout the United States, Canada, Puerto Rico, and Curacao providing demonstrations of the procedure.¹⁰⁸ His biographer relates that:

[o]n one five-week summer trip that year, [1951] he drove 11,000 miles with a station wagon loaded, in addition to camping equipment, with an electroconvulsive shock box, a dictaphone, a file cabinet filled with patient records, photographs, and correspondence;

¹⁰⁴Harvey G. Simmons, “Psychosurgery and the Abuse of Psychiatric Authority in Ontario” (1987) 12:3 *Journal of Health Politics, Policy and Law* 537 at 540. Dr. K.G. McKenzie, a neurosurgeon, performed the first operation.

¹⁰⁵The first 19 lobotomy operations in 1944 were all performed on women. In addition, of the 150 lobotomies performed at Toronto General Hospital from 1948 to 1952, 109 were performed on women, while only 38 were conducted on men: see Simmons, *supra* note 104 at 540.

¹⁰⁶*Ibid.*

¹⁰⁷Breggin, *supra* note 78 at 31.

¹⁰⁸Shorter, *supra* note 66 at 227.

his surgical instruments were in his pocket.¹⁰⁹

Freeman's use of an unsterilized ice pick has been criticized, as has his technique:

"...he sometimes showed off by stabbing the patient through both eye sockets at once with an ice pick in each hand."¹¹⁰ Although such practices are unthinkable today, Dr. Freeman was the Director of Neurology and Psychiatry at George Washington University in the District of Columbia and had been honoured with several awards.¹¹¹

The excising of a portion of a person's frontal lobe was done without any concrete evidence of benefit to the patient. It was soon acknowledged that the main benefit of performing lobotomies accrued to the nursing staff and the hospital administration: "[t]he leucotomy program at this hospital has till recently been aimed at alleviating the ward management problem with chronic, disturbed patients. Hence the great majority of our operated series is comprised of such cases."¹¹² The response was similar at another hospital:

Our first thought was to give lobotomies to the chronically

¹⁰⁹Shorter, supra note 66 at 227, citing Elliot Valenstein, Great and Desperate Cures, at 229.

¹¹⁰Breggin, supra note 78 at 32.

¹¹¹Ibid.

¹¹²Simmons, supra note 104 at 542, quoting Doig, 1957.

assaultive, destructive and soiling group of patients that more or less regularly had to be secluded. Our thought was that we probably might not be able to get too many of these patients out of hospital, but we would create an easier nursing situation in the hospital.¹¹³

Not only were the nurses benefitted because of easier ward management, but psychiatrists were able to achieve some of the much desired recognition and respect accorded to their medical colleagues. By performing lobotomies, a surgical procedure, to treat mental illness, they were bringing their profession in line with medical practitioners: there was an "...enthusiastic reception to a medical, indeed a surgical, procedure which helped to blur the distinction between the practice of physical and psychiatric medicine."¹¹⁴

Psychosurgery is not illegal today but is infrequently used in the treatment of psychiatric illness. The Ontario Mental Health Act¹¹⁵ states:

s. 49. (1) Psychosurgery.--Psychosurgery shall not be administered to an involuntary patient, to a person who is incapable of giving or refusing consent to psychosurgery on his or her own behalf for the purposes of the *Health Care Consent Act, 1996*, or to a person who is remanded or detained in a psychiatric facility pursuant to the *Criminal Code* (Canada). 1987, c. 37, s. 11; 1992, c. 32, s. 20 (39); 1996, c. 2, s. 72 (30).

¹¹³Simmons, *supra* note 104 at 542, quoting the superintendent of the Hamilton Hospital, December 15, 1958.

¹¹⁴*Ibid.* at 540.

¹¹⁵R.S.O. 1990, c. M.7.

(2) Same.--Psychosurgery is any procedure that, by direct or indirect access to the brain, removes, destroys or interrupts the continuity of histologically normal brain tissue, or that inserts indwelling electrodes for pulsed electrical stimulation for the purpose of altering behaviour or treating psychiatric illness, but does not include neurological procedures used to diagnose or treat organic brain conditions, intractable physical pain or epilepsy, if these conditions are clearly demonstrable. 1987, c. 37, s. 11; 1992, c. 32, s. 20 (39).

I) Other Forms of Surgical Interventions

In addition to the administration of medications, some psychiatrists, who believed that certain parts of the body had some connection to mental illness, performed surgical procedures in an attempt to sever this connection. This belief centered predominantly around the reproductive or sexual organs. Dr. Isaac Baker-Brown, a physician from Great Britain, performed clitoridectomies in an attempt to treat mental illness in women in the middle 19th century.¹¹⁶

In Ontario, Dr. Richard Bucke, superintendent of the London Psychiatric Hospital, was also convinced that surgical intervention could alleviate mental illness. He believed that “insane masturbation”¹¹⁷ could be prevented by inserting a wire through a male patient’s foreskin. After twenty-one operations Dr. Bucke concluded that this procedure was a failure and ceased performing it in 1877. He

¹¹⁶Shortt, *supra* note 29 at 142.

¹¹⁷*Ibid.* at 125.

was not convinced, however, that surgical intervention could not be beneficial. In 1895 Dr. Bucke began performing gynecological surgery on women because he believed that the reproductive organs were linked to the brain.¹¹⁸ Over a five year period Dr. Bucke performed various types of gynecological surgery on 209 women, believing such surgery could alleviate mental illness.¹¹⁹ Five patients died but Dr. Bucke reported a 64% rate of improvement: upon subsequent review of the doctor's records these claims have been said to be unsubstantiated.¹²⁰

Conclusion

Thus it can be seen that many abuses in the guise of therapy could be found in practice and the law with respect to committal and involuntary treatment did little

¹¹⁸Shortt, supra note 29 at 141-42.

¹¹⁹Ibid. at 143. Peter A. Rechnitzer, R.M. Bucke (Journey to Cosmic Consciousness) (Markham: Associated Medical Services & Fitzhery & Whiteside, 1994) at 191 reports that Bucke's gynecological diagnoses were characterized as follows:

Endometritis	29
Prolapsed Uterus	68
Lacerated Perineum	33
Lacerated Cervix	29
Hypertrophied Cervix	6
Retroverted Uterus	15
Tumour	31
Unknown	17

¹²⁰Shortt, supra note 29 at 148-49.

to prevent such abuses. The laws were reformed and protective measures were put in place. However, there continues to be dissatisfaction with the current state of the law regarding involuntary hospitalization and treatment in Ontario. It is to a review of the current law regarding commitment and involuntary treatment in Ontario that I now turn.

CHAPTER 2--CURRENT LEGAL REGIME

Introduction

Legislation regarding psychiatric hospitalization and capacity to consent to treatment is found in Ontario in three main statutes: the Mental Health Act,¹²¹ the Substitute Decisions Act, 1992,¹²² and the Health Care Consent Act, 1996.¹²³ This set of legislation is extensive, especially in comparison to some other Canadian jurisdictions.¹²⁴ In addition to being complex, Ontario's law regarding committal and treatment is in a considerable stage of flux: in the course of eight years, under two successive governments, the legislation has been changed or amended seven times.¹²⁵ This amount of change, in itself, may indicate the continued

¹²¹R.S.O. 1990, c. M.7.

¹²²S.O. 1992, c. 30.

¹²³S. O. 1996, c. 2, Sch. A.

¹²⁴For example, Nova Scotia does not have a separate Mental Health Act, but combines general and psychiatric hospitals together in the Hospitals Act, R.S.N.S. 1989, c. 208.

¹²⁵Beginning in 1991, under the former NDP government the following changes were made:

- (1) Consent to Treatment Act, 1992, S.O. 1992, c. 31 proclaimed
- (2) Substitute Decisions Act, 1992, S.O. 1992, c. 30 proclaimed
- (3) Advocacy Act, 1992, S.O. 1992, c. 26 proclaimed
- (4) Consent and Capacity Statute Law Amendment Act, S.O. 1992, c.32 proclaimed.

Following much criticism of the above legislation, especially regarding the complexity and difficulty of implementing the requirements in clinical practice, the Progressive Conservative government made sweeping changes:

- (a) Advocacy Act, 1992 was repealed in 1995;

dissatisfaction that many persons in Ontario feel regarding this area of the law. It also may poignantly reflect the difficulty that the law has in addressing complex issues surrounding civil rights, health care concerns, and societal expectations.

Since the law regarding psychiatric hospitalization and capacity to consent to treatment is so complex in Ontario, I will review it in depth here. To begin, I will set out the current legislation regarding psychiatric hospitalization of voluntary patients, detainees, and involuntary patients. I will then review the case law pertaining to hospitalization. Sections of the legislation that have been misinterpreted or misapplied by health care professionals, the public, patients and even boards of review will be particularly highlighted. The common law principles regarding restraint will also be reviewed.

Next, I will consider the status of the law regarding treatment. The current legislation pertaining to treatment will be set out, followed by a review of the case law in this area. The common law regarding treatment will also be highlighted.

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- (b) Consent to Treatment Act, 1992 was repealed in 1996;
 - (c) Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A. was proclaimed into force on March 29, 1996.

Finally, I will explore issues that arise at the intersection of committal and treatment. The following scenarios will be specifically reviewed: involuntary and incapable patients; involuntary and capable patients; voluntary and capable patients; and, voluntary and incapable patients. Through this exploration the dilemma driving this thesis will come into focus: how is the situation of a voluntary, treatment incapable patient, who refuses to take medications orally or to comply with treatments that have been approved by his substitute decision-maker, to be addressed?

I. Hospitalization

A) The Mental Health Act¹²⁶

a) Voluntary Patients

There are three ways in which a person may become a voluntary patient in a psychiatric facility. First, a person may be admitted directly as a voluntary patient as envisioned by s. 12 of the Mental Health Act.¹²⁷ Second, a person may become a voluntary patient after an application for psychiatric assessment has been

¹²⁶R.S.O. 1990, c. M.7.

¹²⁷R.S.O. 1990, c. M.7, s. 12 states:

Admission of informal or voluntary patients. --Any person who is believed to be in need of the observation, care and treatment provided in a psychiatric facility may be admitted thereto as an informal or voluntary patient upon the recommendation of a physician. R.S.O. 1980, c. 262, s. 8; 1986, c. 64, s. 33 (5).

completed, but the criteria for involuntary admission have not been made out.¹²⁸

Third, an involuntary certificate may lapse.¹²⁹

There is no definition of a voluntary patient in the Mental Health Act. However, an Ontario Psychiatric Review Board,¹³⁰ in a discussion of the meaning of the term, has ruled that "...the term clearly connotes a situation wherein the individual has the opportunity to exercise his or her own free will."¹³¹

¹²⁸R.S.O. 1990, c. M.7, s. 20 (1) (b) states:

Duty of attending physician.--The attending physician, after observing and examining a person who is the subject of an application for assessment under section 15 or who is the subject of an order under section 32,

.....
(b) shall admit the person as an informal patient or voluntary patient if the attending physician is of the opinion that the person is suffering from mental disorder of such a nature or quality that the person is in need of the treatment provided in a psychiatric facility and is suitable for admission as an informal or voluntary patient;...

¹²⁹R.S.O. 1990, c. M.7, s. 20 (6) states:

Change of status, where period of detention has expired.--An involuntary patient whose authorized period of detention has expired shall be deemed to be an informal or voluntary patient. R.S.O. 1980, c. 262, s. 14 (6); 1986, c. 64, 2. 33 (16), *part*.

¹³⁰This review body is now titled the Consent and Capacity Board.

¹³¹Re J.G. (November 11, 1993, unreported). See Hy Bloom and Michael Bay, A Practical Guide to Mental Health, Capacity, and Consent Law of Ontario (Toronto: Carswell, 1996) at 122.

A voluntary patient is one who may be discharged from a facility on request.¹³²

Indeed, as stated in s. 14 of the Mental Health Act.¹³³

[n]othing in this Act authorizes a psychiatric facility to detain or restrain an informal or voluntary patient.

The authority to restrain or detain a voluntary patient, if it is to be found, must be located in either the Substitute Decisions Act, 1992¹³⁴ or the Health Care Consent Act, 1996.¹³⁵

b) Detainees and Involuntary Patients

Persons may be brought into a psychiatric hospital against their will by means of an Application for Psychiatric Assessment (commonly referred to as an “APA” or “Form 1”).¹³⁶ While such persons are commonly referred to as involuntary

¹³²Mental Health Act, R.S.O. 1990, c. M.7, s. 14. It should be noted that voluntary patients may not be as free to leave a facility as perhaps thought. Some hospitals require that all persons see a physician prior to discharge. This, at the very least, implies a delay in departure. Furthermore, if the physician believes that the patient should remain hospitalized and if the patient is unwilling to do so voluntarily, the patient may be certified as an involuntary patient if they meet the criteria. Thus seeking to leave, as a voluntary patient, may trigger involuntary committal.

¹³³R.S.O. 1990, c. M.7.

¹³⁴S.O. 1992, c. 30.

¹³⁵S.O. 1996, c. 2, Sch. A.

¹³⁶In addition to physicians, Justices of the Peace and Peace Officers are given powers under the Mental Health Act to detain any person they suspect is suffering from a mental illness and may cause serious harm to themselves, harm to someone else or is

patients, such a designation is incorrect: such persons are not patients, but detainees.¹³⁷

S. 15 (1) of the Mental Health Act¹³⁸ states:

Where a physician examines a person and has reasonable cause to believe that the person,

- (a) has threatened or attempted or is threatening or attempting to cause bodily harm to himself or herself;
- (b) has behaved or is behaving violently towards another person or has caused or is causing another person to fear bodily harm from him or her; or
- (c) has shown or is showing a lack of competence to care for himself or herself,

and if in addition the physician is of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in,

- (d) serious bodily harm to the person;
- (e) serious bodily harm to another person; or
- (f) imminent and serious physical impairment of the person,

the physician may make application in the prescribed form for a psychiatric assessment of the person.

The overt criteria or behaviours necessary for a physician to issue an APA are

exhibiting an inability to care for him or herself: see s. 16 regarding the powers of an order of a Justice of the Peace, and s. 17 in relation to the authority of police officers. It should be noted that the authority of the Justice of the Peace and police officers extends only to authorising or bringing the person before a physician for examination (see s. 16 (3) and s. 17), not for the 72 hour assessment. An examination by a physician consists of an interview and observation of the patient, typically lasting from several minutes (if the patient is very disturbed and/or cannot provide much information) to a few hours. The 72 hour assessment takes place at a psychiatric facility.

¹³⁷R. v. Webers (1994), 95 C.C.C. (3d) 334 at 347 (Ont. Ct. (Gen. Div.)) (hereinafter Webers). See also Bloom and Bay, supra note 131 at 123.

¹³⁸R.S.O. 1990, c. M.7.

quite broad: they include past behaviour (e.g. “has threatened”), present behaviour (e.g. “is threatening”) and another person’s fear of potential behaviour (e.g. “is causing another person to fear bodily harm from him or her”). However, not only must the past, present or potential behaviour criteria be met, the physician must also believe that the person has a mental disorder that will result in serious bodily harm to himself, to another, or “imminent and serious physical impairment of the person”.¹³⁹

An APA is sufficient authority for anyone to deliver the named person to a psychiatric facility.¹⁴⁰ Once there, a person may be detained for psychiatric examination for 72 hours.¹⁴¹

An involuntary patient is defined under the Mental Health Act¹⁴² as “...a person who is detained in a psychiatric facility under a certificate of involuntary admission or a certificate of renewal”.¹⁴³ A certificate of involuntary admission may be filled out by a physician after examining a detainee in hospital under the

¹³⁹Mental Health Act, R.S.O. 1990, c. M. 7, s. 15.

¹⁴⁰Mental Health Act, R.S.O. 1990, c. M. 7, s. 15 (a).

¹⁴¹Mental Health Act, R.S.O. 1990, c. M.7, s. 15 (b).

¹⁴²R.S.O. 1990, c. M.7.

¹⁴³R.S.O. 1990, c. M.7, s. 1.

authority of s. 15 (application for psychiatric assessment), or at any time a voluntary patient meets the criteria set out in s. 20 (5):

Conditions precedent to making of certificate of involuntary admission or certificate of renewal.--The attending physician shall not complete a certificate of involuntary admission or a certificate of renewal unless, after he or she has examined the patient, he or she is of the opinion both,

- (a) that the patient is suffering from mental disorder of a nature or quality that likely will result in,
 - (i) serious bodily harm to the patient,
 - (ii) serious bodily harm to another person, or
 - (iii) imminent and serious physical impairment of the patient,

unless the patient remains in the custody of a psychiatric facility; and

- (b) that the patient is not suitable for admission or continuation as an informal or voluntary patient.

The physician must believe that the person has a mental illness and that such illness will likely result in serious bodily harm to that person or someone else, or imminent and serious impairment of that person.

A certificate of involuntary admission is sufficient authority to detain a person in a psychiatric facility for a maximum of two weeks.¹⁴⁴ Certificates of renewal are issued subsequent to certificates of involuntary admission and may authorize holding a person involuntarily for periods of one, two or three additional

¹⁴⁴Mental Health Act, R.S.O. 1990, c. M.7, s. 20 (4) (a).

months.¹⁴⁵

An involuntarily committed person, or her representative, may make an application to the Consent and Capacity Board to challenge her involuntary status.¹⁴⁶ A decision of the Board may be appealed to the Ontario Court (General Division) on a question of law or fact or both.¹⁴⁷

The legislation regarding detainees and involuntary patients has been considered in several cases. In particular, the necessity of the commission of an act before certification can be initiated, the connection that must exist between the mental disorder and the risk of harm, and the standard of proof required to be met to justify involuntary commitment have all been the subject of judicial interpretation. In addition, there has been much judicial consideration of the meaning of different terms or phrases contained in the legislation. For instance, the phrase “likely will

¹⁴⁵Mental Health Act, R.S.O., c. M.7, s. 20 (4) (b) (i), s. 20 (4) (b) (ii), s. 20 (4) (b) (iii). As long as a patient meets the criteria for involuntary committal, subsequent certificates of renewal may be completed by the physician: that is, renewal upon renewal may be completed. The longest period a person may be held on one renewal certificate, without the completion of a subsequent renewal, is three months. Once a person becomes voluntary, in the event of subsequent need for certification, the same process and time frames that applied for the initial involuntary certificate would pertain.

¹⁴⁶Mental Health Act, R.S.O. 1990, c. M.7, s. 39 (1). Note: the Consent and Capacity Review Board is the new name for the previous Psychiatric Review Board in Ontario.

¹⁴⁷Mental Health Act, R.S.O. 1990, c. M.7, s. 48 (1).

result in” in relation to the probability of the patient becoming a danger to himself, others, or exhibiting an inability to care for himself, the meaning of “serious physical impairment of the person,” and “imminent” have all received judicial scrutiny. The following section will review the case law in Ontario that has considered the issues listed above.

- i) **persons may be detained for examination under s. 15 or held involuntarily pursuant to s. 20 absent an overt act (e.g. violence to self or others)**

In Starnaman v. Penetanguishene Mental Health Centre¹⁴⁸ the Ontario Court (General Division) stated that the “Mental Health Act doesn’t require proof of commission of an ‘overt act.’”¹⁴⁹ There, a man diagnosed as a pedophile with a “history of repeated incest, sexual coercion and premeditation in his offences”¹⁵⁰ challenged his involuntary detention. Although he had not engaged in such behaviour for some time, the Court held that an overt act was not a necessary precondition for continued detention as an involuntary patient. Judge O’Driscoll

¹⁴⁸[1994] O.J. No. 1958 (Q.L.) (hereinafter Starnaman).

¹⁴⁹Ibid. at para. 36.

¹⁵⁰Ibid. at para. 22.

cited both Dayday v. MacEwan¹⁵¹ and McKay v. O'Doherty¹⁵² in support of this principle.

Similarly, the Ontario District Court in McKay v. O'Doherty¹⁵³ upheld a review board's decision that a woman's involuntary detention was legal even though no overt action had transpired. The woman had a history of paranoid schizophrenia and believed that other people were impersonating and following her. While a student in a Law and Security course she went to the college and threatened to return and shoot 22 people she had placed on a "hit list" if she was not allowed to graduate from her program and join the R.C.M.P.. In relation to the appellant's counsel's position that his client was detained unlawfully because she had never carried through with her threats, the Court replied:

Neither s. 9 [now s. 15] nor s. 14 [now s. 20] of the Mental Health Act requires an overt act or commission before an involuntary committal can be made. In this case there was a preponderance of evidence of great cogency that the mental disorder of the appellant had deteriorated to the point where her delusions were beginning to overwhelm her, and she was acting out of control.¹⁵⁴

¹⁵¹(1987), 62 O.R. (2d) 588 at 598 (Dist. Ct.) (hereinafter Dayday).

¹⁵²[1989] O.J. No. 965 (Dist. Ct.) (Q.L.) (hereinafter McKay).

¹⁵³Ibid. See also Richard D. Schneider, The 1996 Annotated Ontario Mental Health Statutes (Toronto: Carswell, 1996) at 11.

¹⁵⁴McKay, supra note 152 at 19-20.

Citing McKay,¹⁵⁵ Judge Bolan of the Ontario Court (General Division) overturned a finding of a review board in Middel v. Adams.¹⁵⁶ In this case, a person involuntarily detained at a psychiatric hospital had a knife in her possession and had threatened bodily harm to members of the nursing staff. Judge Bolan stated:

In finding that the evidence fell short of establishing a likelihood of danger to anyone, the Board referred to the fact that not a shred of evidence indicated that Middel ever carried out any of the threats she ever made. This is clearly an error in law.

.....
It suffices to show that there is a likelihood of such an event occurring . Dr. Adams came to this conclusion based on evidence of past threats as well as the nature of the mental disorder itself.¹⁵⁷

Health professionals are often unaware that there does not need to be an overt act of violence or danger for a person to be subject to the detaining provisions of the Mental Health Act. A common misconception is “I can’t certify him because he hasn’t hurt anybody yet.” However, this is an error in law.

¹⁵⁵McKay, *supra* note 152 at 19-20.

¹⁵⁶[1993], O.J. No. 2864 (C.J. (Gen. Div.)) (Q.L.) (hereinafter Middel).

¹⁵⁷Ibid. at para. 7.

ii) **“likely will result in”**¹⁵⁸

Section 20 of the Act stipulates that the person must have a mental illness that “likely will result in” serious bodily harm to self, others, or imminent and serious physical impairment to the person. “Likely” has been defined as “[h]aving an appearance of truth or fact; that looks as if it would happen, be realized or proved to be what is alleged or suggested. Probable.”¹⁵⁹ Therefore, as Bloom and Bay point out:

The MHA does not require that an attending physician be certain that a particular harm will occur before the physician admits or continues a patient as an involuntary patient. Rather, the Act requires that the attending physician form an opinion about whether or not, as a result of mental disorder, one or more of the harms listed in s. 20 (5) is likely to occur unless the patient remains in the custody of a psychiatric facility.... In considering whether or not harm is “likely”, the courts have held that “likely” means “probable”, not “highly probable.”¹⁶⁰

iii) **“serious physical impairment of the person”**¹⁶¹

Persons with mental illness can experience impairment due to their condition that seriously affects their ability to care for themselves. “This ground contemplates

¹⁵⁸Mental Health Act, R.S.O. 1990, c. M.7, ss. 15 (1) (f) and 20 (5) (a) (iii).

¹⁵⁹Azhar v. Anderson (June 28, 1985), Doc. No. Toronto 609/85 (Ont. Dist. Ct.) (hereinafter Azhar). Cited with approval in McKay *supra* note 152 at 19.

¹⁶⁰Bloom and Bay, *supra* note 131 at 127, citing Azhar *supra* note 159.

¹⁶¹In s. 15 (1) (f) and s. 20 (5) (iii) of the Mental Health Act.

the situation where a person's mental disorder interferes in such a substantial way with his or her abilities to provide for at least minimal bodily needs that the person is at serious risk."¹⁶² In Foran v. O'Doherty¹⁶³ Judge Fitzgerald indicated that Mr. Foran should remain in hospital as he accepted that without such care he would "take up his aimless and slovenly existence which would ultimately lead to physical deterioration."¹⁶⁴ However, he overturned the review board's decision to confirm the involuntary certificate because there was not convincing evidence that his discharge would result in "imminent and serious physical impairment."

The resulting physical impairment must be serious. In Tran v. Ralyea¹⁶⁵ Judge Brown accepted that serious bodily harm "must be more than trifling" as recognized in Dayday v. McEwan.¹⁶⁶ Judge Brown cautioned that:

[t]here may, for example, be many persons with mental disorders who may, in response to the mental disorder be a nuisance to themselves and/or others but their behaviour may fall far short of there being a likelihood of serious bodily harm or harm beyond a mere trifling nature.¹⁶⁷

¹⁶²Bloom and Bay, supra note 131 at 87.

¹⁶³[1986], O.J. No. 2146 (Dist. Ct.) (Q.L.) (hereinafter Foran).

¹⁶⁴Ibid. at 4-5.

¹⁶⁵[1993], O.J. No. 1261 (Ct. J. (Gen. Div.)) (Q.L.) (hereinafter Tran).

¹⁶⁶Dayday, supra note 151.

¹⁶⁷Tran, supra note 165 at para. 9.

It has also been recognized that a person may be so disordered that his conduct may make him the target of harm by others. In Levinskas v. Hutson¹⁶⁸ the Court ruled that such a risk would be grounds to hold a person under the “imminent and serious physical impairment of the person” criteria of the Act.¹⁶⁹

iv) “imminent”¹⁷⁰

The requirement of imminence only applies to the risk of serious physical impairment of the person.¹⁷¹ Therefore, the possibility that a person may harm himself or others does not have to “imminent” in order for involuntary certification to occur. The term “imminent” in relation to serious physical impairment of the person has been broadly interpreted by the courts¹⁷² in most, but not all, instances. In G. (G.) v. Swamy¹⁷³ the Ontario District Court affirmed a Board of Review decision that ruled that imminent and serious physical impairment could result if a

¹⁶⁸(1989), 16 A.C.W.S. (3d) 143 (Ont. Dist. Ct. (Gen. Div.)) (hereinafter Levinskas).

¹⁶⁹Ibid. See also Bloom and Bay, supra note 131 at 87.

¹⁷⁰In s. 15 (1) (f) and s. 20 (5) (iii) of the Mental Health Act.

¹⁷¹As Michael Bay points out, contrary to the “Toronto Star version of the Mental Health Act”, imminent only applies to physical impairment: see Bay, supra note 16 at 125.

¹⁷²Bloom and Bay, supra note 131 at 138.

¹⁷³(April 4, 1986), Doc. No. Thunder Bay 1179/86 (Ont. Dist. Ct.).

patient was discharged with a history of medication noncompliance. Should this person not take her medications, she would deteriorate within “a matter of weeks.”¹⁷⁴ The Court held that this time frame was sufficient to satisfy the meaning of “imminent.”¹⁷⁵

Similarly, in B. (L.) v. O’Doherty¹⁷⁶ the Court held that a person with delusions that interfered with her understanding of her medical condition, and a history of increased weight and salt intake that greatly increased her chance of having a stroke, satisfied the criteria for “imminent and serious physical impairment”. Absent continued hospitalization, the court ruled that the patient was at risk of suffering a stroke.

As Bloom and Bay point out:

A refusal to take prescribed medication or a history of non-compliance with treatment may place a patient at risk of imminent and serious physical impairment, particularly where the patient has a history of decompensating within about a month of discharge from a psychiatric facility and thereafter being at risk of serious physical

¹⁷⁴Transcript at p. 10.

¹⁷⁵Note that the Court listed as reasons for this person’s probable future decompensation non-compliance with medications and an “apparent lack of community resources”. As will be discussed further, it is highly controversial that persons may be denied their liberty as a result of fiscal restraint or administrative inaction.

¹⁷⁶(April 14, 1986), Doc. No. 1226/86 (Ont. Dist. Ct.).

impairment.¹⁷⁷[emphasis added]

However, the Ontario District Court has also held that a failure to take prescribed medications following discharge that would likely lead the person to “...take up his aimless and slovenly existence which would ultimately lead to physical deterioration” is not sufficient to satisfy the legislative mandate for “imminent and serious physical impairment”.¹⁷⁸ Judge Fitzgerald stated:

I have challenged the respondent to show me in the evidence what specific imminent and serious harm will likely result from this patient’s release beyond some future conjectural possibility. He is unable to do so.¹⁷⁹ [emphasis added]

The Judge then “regretfully”¹⁸⁰ held that the Board of Review had erred in its decision and rescinded the involuntary certificate.

v) necessary connection between the mental disorder and the risk of harm¹⁸¹

Sections 15 (1) and 20 (5) are both clearly drafted to indicate that not only must there be a risk of harm to self, harm to others, or a lack of competence to care for

¹⁷⁷Bloom and Bay, supra note 131 at 138.

¹⁷⁸Foran, supra note 163.

¹⁷⁹Ibid. at 7.

¹⁸⁰Ibid. at 8.

¹⁸¹Bloom and Bay, supra note 131 at 128.

self, but this risk must be present as a result of a mental disorder. "Mental disorder" is defined broadly in the Mental Health Act¹⁸² as "any disease or disability of the mind".¹⁸³ As the courts in Kletke v. U. (D.),¹⁸⁴ Levinskas v. Hutson¹⁸⁵ and Diilanceai v. Bell¹⁸⁶ have held, there must be a connection between the disease and the outcome of harm to self or others, or the lack of competence to care for self.

In Diilanceai v. Bell¹⁸⁷ Judge Perras of the Ontario District Court held that simply because a person with a mental illness had no money, no source of funds, no place to stay, and no clear plans for his future was not justification for certification. He stated:

...under the present law, it does not appear that any review board can justify confirming a certificate of involuntary admission on the basis of a finding of that kind. The cause that will likely result in the imminent and serious physical impairment of the patient needs to be related to the mental disorder suffered by the patient. It is not enough that the impairment might result from a lack of funds or of a

¹⁸²R.S.O. 1990, c. M.7.

¹⁸³S. 1.

¹⁸⁴[1984] O.J. No. 1540 (Dist. Ct.) (Q.L.) (hereinafter Kletke).

¹⁸⁵Supra note 168.

¹⁸⁶[1988] O.J. No. 1079 (Dist. Ct.) (Q.L.) (hereinafter Diilanceai).

¹⁸⁷Ibid.

place to live.¹⁸⁸

vi) standard of proof required for civil commitment

Because of the civil nature of commitment, it has been held that the standard of proof required in circumstances of civil commitment is a balance of probabilities.¹⁸⁹ However, because of the deprivation of liberty involved, “there must be clear and compelling evidence to support a patient’s involuntary detention in a psychiatric facility”.¹⁹⁰ In addition, the trier of fact may submit such evidence to a higher degree of scrutiny.¹⁹¹

B) Health Care Consent Act, 1996¹⁹²

There are three potential persons who may have authority to consent to the admission of an incapable person to a psychiatric facility: a guardian, a person appointed through a power of attorney for personal care, and a substitute decision-

¹⁸⁸Diilanceai, supra note 186 at 14.

¹⁸⁹See Greggor v. Riverview Hospital, [1992] B.C. J. No. 694 (S.C.) (Q.L.); McKay, supra note 152; Azhar, supra note 159; G. (G.) v. Swamy, supra note 173; Diilanceai, supra note 186; Dayday, supra note 151.

¹⁹⁰Bloom and Bay, supra note 131, citing G. (G.) v. Swamy, supra note 173 and McKay, supra note 152. See also Foran, supra note 163 at 8 and Tran, supra note 165 at paragraph 7.

¹⁹¹McKay, supra note 152 at 18.

¹⁹²S.O. 1996, c. 2, Sch. A.

maker.¹⁹³ First, under the authority of this Act, a guardian appointed after an application has been made to the court through the procedure outlined in the Substitute Decisions Act, 1992¹⁹⁴ may have the authority to consent to an incapable person's admission to a psychiatric facility.¹⁹⁵ Section 24 states:

(2) Objection, psychiatric facility.-- If the incapable person is 16 years old or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to his or her admission may be given only by,

(a) his or her guardian of the person, if the guardian has authority to consent to the admission¹⁹⁶

Second, a person who has been granted the incapable person's power of attorney may have the power to consent to the incapable person's admission to a psychiatric facility, over his or her objection. This power would only exist if the authority to give such consent was explicitly contained in the power of attorney.¹⁹⁷ Such

¹⁹³A substitute decision-maker is essentially any one who makes a decision on behalf of another. While guardians and persons who have been appointed by another in a Power of Attorney for Personal Care are substitute decision-makers, the term, used in this section relates to persons who have not been given explicit authority through a Court Order or POAPC but have been called upon to make a decision for another.

¹⁹⁴S.O. 1992, c. 30, s. 55.

¹⁹⁵A guardian may be full or partial and have differing authority: this will be explained further in the following section on the Substitute Decisions Act, 1992.

¹⁹⁶Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 24 (2) (a).

¹⁹⁷Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 24 (2) (b) states: **Objection, psychiatric facility.--**If the incapable person is 16 years old or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to his or her admission may be given only by,

Powers of Attorney are often referred to as Ulysses contracts.¹⁹⁸ If the authority was not provided in the power of attorney, the person named as the attorney for personal care decisions could not consent to the admission over the incapable person's objections.

Finally, a substitute decision-maker may authorize the admission of an incapable person to a psychiatric facility if the incapable person, who is over 16, does not refuse admission for the purpose of treatment. Sections 24 (1) and (2) of the Act state:

(1) Admission to hospital, etc.--Subject to subsection (2), a substitute decision-maker who consents to a treatment on an incapable person's behalf may consent to the incapable person's admission to a hospital or psychiatric facility or to another health facility prescribed by the regulations, for the purpose of the treatment.

(2) Objection, psychiatric facility.--If the incapable person is 16 years old or older and objects to being admitted to a psychiatric facility for treatment of a mental disorder, consent to his or her admission may be given only by,

(a) his or her guardian of the person, if the guardian has authority

.....

(b) his or her attorney for personal care, if the power of attorney contains a provision authorizing the attorney to use force that is necessary and reasonable in the circumstances to admit the incapable person to the psychiatric facility and the provision is effective under subsection 50 (1) of the Substitute Decisions Act, 1992.

¹⁹⁸See Chapter 2, p. 75-76

- to consent to the admission; or
- (b) his or her attorney for personal care, if the power of attorney contains a provision authorizing the attorney to use force that is necessary and reasonable in the circumstances to admit the incapable person to the psychiatric facility and the provision is effective under subsection 50 (1) of the *Substitute Decisions Act, 1992*.

The Health Care Consent Act, 1996 does acknowledge another situation wherein a person may be restrained or confined: section 7 of the Act states:

Restraint, confinement.--This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.

Therefore, should a patient act out towards himself or another, the members of the health care team would be justified, and in fact, would have a duty to use physical or manual restraint, or to confine the person.

At common law a person "...may use force to rescue a person, even a stranger, from attack."¹⁹⁹ A similar principle has been codified in the Criminal Code in s. 37:

- (1) Every one is justified in using force to defend himself or any one under his protection from assault, if he uses no more force than is necessary to prevent the assault or the repetition of it.
- (2) Nothing in this section shall be deemed to justify the wilful infliction of any hurt or mischief that is excessive, having

¹⁹⁹Webers, supra note 137.

regard to the nature of the assault that the force used was intended to prevent.²⁰⁰

Therefore, a caregiver would be justified in restraining a patient in order to protect other patients, or themselves from suffering injuries. This justification could be seen to be as a result of the relationship of the caregiver to the patient, or because the patient could be characterized as a person under his or her protection.

The Supreme Court of Canada ruled in 1978 that a hospital had a duty to protect its patients from the foreseeable violent acts of a psychiatric patient.²⁰¹ In Lawson v.

Wellesley Hospital the Court stated:

It was not doubted by counsel for the parties that at common law a hospital, especially one providing treatment for mentally-ill persons, would be under a common law liability if by reason of its failure to provide adequate control and supervision injury occurred to third parties by reason of the conduct or behaviour of a patient.²⁰²

The situation of restraining a patient to prevent them from self harm is not as clear. Common sense dictates that if a person is an inpatient at a psychiatric facility and he attempts to kill or harm himself, the staff will be justified, and most would say,

²⁰⁰Criminal Code, R.S.C. 1985, c. C-46.

²⁰¹Lawson v. Wellesley Hospital (1978), 76 D.L.R. (3d) 688 (hereinafter Lawson).

²⁰²Ibid. at 691. See also Stewart v. Extendicare Ltd. [1986] 4 W.W.R. 559 (Sask. Q.B.) where a patient with a history of violence struck another patient and the facility was held liable for failing to ensure the safety of the resident.

required to prevent this from occurring. The person would certainly then meet the criteria for formal committal. As one author has put it:

[w]hen the threat posed by the mentally incapable person is a threat only to himself, the courts will likely infer the consent of the relevant person (the substitute consent-giver) to the imposition of restraints; or, to achieve the same sensible end, will press into service the so-called emergency doctrine.²⁰³

However, it should be noted that this common law authority to restrain and detain exists only in response to the possibility of the patient becoming a danger to himself or others: that is, a psychiatric emergency situation. It cannot be used as justification to restrain or detain a voluntary patient who is resisting treatment. In particular, it is this author's belief that for the time the voluntary, treatment incapable person who is resisting treatment, is physically restrained in order to be involuntarily treated, she has been detained. This common law exception cannot be used as authority for such an action.

C) **Substitute Decisions Act, 1992**²⁰⁴

The Substitute Decisions Act, 1992 is concerned with mainly two types of persons who may make decisions on behalf of another: a guardian and a person

²⁰³Barney Sneiderman, John C. Irvine and Philip H. Osborne, Canadian Medical Law (Toronto: Carswell, 1995) at 162.

²⁰⁴S.O. 1992, c. 30.

acting under the authority of a power of attorney. A guardian of a person²⁰⁵ must be court appointed. Section 55 states:

(1) Application for appointment.--The court may, on any person's application, appoint a guardian of the person for a person who is incapable of personal care and, as a result, needs decisions to be made on his or her behalf by a person who is authorized to do so.

(2) Prohibition.--The court shall not appoint a guardian if it is satisfied that the need for decisions to be made will be met by an alternative course of action that,

- (a) does not require the court to find the person to be incapable of personal care; and
- (b) is less restrictive of the person's decision-making rights than the appointment of a guardian.²⁰⁶

A court may grant either full or partial guardianship.²⁰⁷ Full guardianship could be ordered if the person was found incapable of making personal care decisions in all of the areas outlined in s. 45 of the Act which states:

Incapacity for personal care.--A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.²⁰⁸

²⁰⁵Substitute Decisions Act, 1992 also makes provisions for guardians of property: see ss 15, 16, and 22.

²⁰⁶Substitute Decisions Act, 1992, S.O. 1992, c. 30.

²⁰⁷Substitute Decisions Act, 1992, S.O. 1992, c. 30, ss. 59 and 60.

²⁰⁸Substitute Decisions Act, 1992, S.O. 1992, c. 30.

The authority of a person who has been granted full guardianship of another in respect of personal care is quite extensive. Section 59 (2) and (3) set out those powers.²⁰⁹ A guardian with full authority may consent to an incapable person's admission to a psychiatric facility for the purposes of treatment, even over the

²⁰⁹S. 59 (2) and (3) state:

(2) Powers of guardian.--Under an order for full guardianship, the guardian may,

- (a) exercise custodial power over the person under guardianship, determine his or her living arrangements and provide for his or her shelter and safety;
- (b) be the person's litigation guardian, except in respect of litigation that relates to the person's property or to the guardian's status or powers;
- (c) settle claims and commence and settle proceedings on the person's behalf, except claims and proceedings that relate to the person's property or to the guardian's status or powers;
- (d) have access to personal information, including health information and the release of that information to another person, except for the purposes of litigation that relates to the person's property or to the guardian's status or powers;
- (e) on behalf of the person, make any decision to which the *Health Care Consent Act, 1996* applies;
- (e.1) make decisions about the person's health care, nutrition and hygiene
- (f) make decisions about the person's employment, education, training, clothing and recreation and about any social services provided to the person; and
- (g) exercise the other powers and perform the other duties that are specified in the order. 1996, c. 2, s. 37 (1).

(3) Power to apprehend person.--If the guardian has custodial power over the person and the court is satisfied that it may be necessary to apprehend him or her, the court may in its order authorize the guardian to do so; in that case the guardian may, with the assistance of a police officer, enter the premises specified in the order, between 9 a.m. and 4 p.m. or during the hours specified in the order, and search for and remove the person, using such force as may be necessary.

person's objection, under the authority of s. 24 of the Health Care Consent Act, 1996.²¹⁰

The court may also grant partial guardianship: that is, make an order giving the guardian the power to make decisions in one of the areas outlined in s. 45, such as health care, an area in which the person is incapable to make decisions. Section 60 of the Substitute Decisions Act, 1992 provides the authority for the Court to make Orders for partial guardianship.²¹¹ The authority of the guardian must be set out in the Order in relation to the powers listed in s. 59 (2), (3), (4) and (5) of the Substitute Decisions Act, 1992.²¹² Therefore, if an Order was obtained from the Court for partial guardianship in respect of health care, by virtue of s. 24 of the Health Care Consent Act, 1996, a guardian could consent to the admission of an

²¹⁰S.O. 1996, c. 2, Sch. A.

²¹¹S.60 of the Substitute Decisions Act, 1992 relates to partial guardianship:

(1) Partial guardianship.--The court may make an order for the partial guardianship of the person for an incapable person if it finds that he or she is incapable in respect of some but not all of the functions referred to in section 45.

(2) Same.--The order shall specify in respect of which functions the person is found to be incapable.

(3) Powers of guardian.--Under an order for partial guardianship, the guardian may exercise those of the powers set out in subsection 59 (2), (3), (4) and (5) that are specified in the order. 1996, c. 2, s. 38.

²¹²Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 60 (3).

incapable person to a psychiatric facility for the purposes of treatment, even against the patient's own wishes.²¹³

Second, a capable person may execute a power of attorney for personal care which confers authority on a substitute decision-maker to make decisions in the event of future incapacity.²¹⁴ A grantor may authorize her substitute to have her admitted and detained in a psychiatric facility for the purpose of treatment. Section 50 (2) (2) of the Substitute Decisions Act, 1992 provides this authority:

A provision that authorizes the attorney and other persons under the direction of the attorney to use force that is necessary and reasonable in the circumstances to take the grantor to any place for care or treatment, to admit the grantor to that place and to detain and restrain the grantor in that place during the care or treatment.

In addition, a person who has been named under a Power of Attorney for Personal Care [hereinafter "POAPC"] to make decisions on another's behalf in the event of future incapacity has the authority to consent to the incapable person's admission to a psychiatric facility for the purpose of treatment, even absent a specific

²¹³It should be remembered that the provision applies if the person is over 16.

²¹⁴Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 46 (1) states:
Power of attorney for personal care.--A person may give a written power of attorney for personal care, authorizing the person or persons named as attorneys to make, on the grantor's behalf, decisions concerning the grantor's personal care.

provision in the POAPC. The Substitute Decisions Act, 1992,²¹⁵ authorizes a person named as an attorney for personal care to make any decisions to which the Health Care Consent Act, 1996²¹⁶ applies. Section 49 (1) of the Substitute Decisions Act, 1992²¹⁷ states:

When power of attorney effective.--A provision in a power of attorney for personal care that confers authority to make a decision concerning the grantor's personal care is effective to authorize the attorney to make the decision if,

- (a) the *Health Care Consent Act, 1996* applies to the decision and that Act authorizes the attorney to make the decision; or
- (b) the *Health Care Consent Act, 1996* does not apply to the decision and the attorney has reasonable grounds to believe that the grantor is incapable of making the decision, subject to any condition in the power of attorney that prevents the attorney from making the decision unless the fact that the grantor is incapable of personal care has been confirmed.

Therefore, since the power to have a person admitted to a psychiatric facility for the purposes of treatment is provided by the Health Care Consent Act, 1996²¹⁸ in s. 24 (1), a person named as a substitute decision-maker through a Power of Attorney for Personal Care can have the grantor admitted to hospital for treatment,

²¹⁵S.O. 1992, c. 30.

²¹⁶S.O. 1996, c. 2, Sch. A.

²¹⁷S.O. 1992, c. 30.

²¹⁸S.O. 1996, c. 2, Sch. A, s. 24 (1).

even absent a specific provision in the POAPC to do so. However, should the person, 16 years of age or older, refuse admission under the authority of his substitute decision-maker, such admission cannot be authorized.²¹⁹

The Substitute Decisions Act, 1992 does recognize that a person in a facility may be restrained or confined under the authority of the common law, regardless of admission status. S. 66 (11) states:

Common law.--Nothing in this Act affects the common law duty of caregivers to restrain or confine persons when immediate action is necessary to prevent serious bodily harm to them or others.

Again, this authority cannot be used as justification for restraint and confinement of a voluntary patient who is not posing a danger to herself or others. In particular, it cannot be used in order to justify restraining and detaining a voluntary person for the purposes of treatment (as opposed to restraint for the emergency situation).

²¹⁹Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 24 (2). Note that the term substitute decision-maker in this section of the chapter refers to a person who must make a decision for another who is treatment incapable, but does not refer to a guardian or person who has authority under a POAPC to restrain and detain the person for purposes of treatment.

II. Treatment

As noted earlier, legislation regarding mental health is contained in three main pieces of legislation in Ontario: the Mental Health Act,²²⁰ the Health Care Consent Act, 1996,²²¹ and the Substitute Decisions Act, 1992.²²² The word “treatment” is defined only in the Health Care Consent Act, 1996.²²³

Involuntary treatment refers to a situation where an incapable person does not accept the treatment that has been ordered by his physician, and consented to by his substitute decision-maker. For example, if the physician had ordered medication three times per day by mouth, and the patient refused to take it, he could be restrained by the nursing staff and have the medication delivered by injection.²²⁴ Similarly, if electroconvulsive therapy was ordered and the patient refused, nursing staff would be forced to restrain the patient to a stretcher and

²²⁰R.S.O. 1990, c. M.7.

²²¹S.O. 1996, c. 2, Sch. A.

²²²S.O. 1992, c. 30.

²²³See p. 71-72.

²²⁴It should be noted that not all medications can be administered by injection as they are not manufactured in that form (e.g. Lithium Carbonate used in the treatment of people with bipolar affective disorder/manic depression).

administer any additional restraint necessary until the treatment was completed.²²⁵

The authority to administer involuntary treatment is contained in the Health Care Consent Act, 1996²²⁶ and the Substitute Decisions Act, 1992.²²⁷ The Mental Health Act²²⁸ refers to treatment only in reference to the criteria for admission to a psychiatric facility²²⁹ and in relation to instructions regarding psychosurgery.²³⁰

The Health Care Consent Act, 1996²³¹ and the Substitute Decisions Act, 1992²³²

²²⁵As should be apparent, the provision of involuntary treatment to a resisting patient is stressful for all persons involved. Foremost, the patient may be either angry or extremely frightened, and undoubtedly distressed. In addition, the nursing staff, those persons responsible for actually administering the treatment that has been ordered by the physician and consented to by a substitute or attorney, are also placed under much stress. While aware of their role in administering treatment, many are uncomfortable when forced into such a seemingly combative role with the patient that is difficult to merge with the necessity of forming a therapeutic relationship with patients. In addition, there is also the risk of physical injury that can occur when restraining a person who does not wish to receive treatment.

²²⁶S.O. 1996, c. 2, Sch. A.

²²⁷S.O. 1992, c. 30.

²²⁸R.S.O. 1990, c. M.7.

²²⁹S. 12 (regarding informal or voluntary patients), and s. 20 (1) (b) (regarding the admission of voluntary patients following a psychiatric assessment) both state that admission is warranted if the person is in "need of treatment."

²³⁰See p. 79-80.

²³¹S.O. 1996, c. 2, Sch. A.

²³²S.O. 1992, c. 30.

use the words “capable” and “incapable” regarding a person’s ability to make decisions, while many people continue to employ “competent” and “incompetent.” A person may be declared mentally incapable regarding treatment,²³³ property,²³⁴ disclosure²³⁵ or examination of his own clinical record,²³⁶ admission to a care facility,²³⁷ and consent to a personal assistance device.²³⁸ This thesis will concentrate exclusively on persons who have been found to be incapable of making treatment decisions.

²³³Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 18.

²³⁴Mental Health Act, R.S.O. 1990, c. M.7, s. 54.

²³⁵Mental Health Act, R.S.O. 1990, c. M.7, s. 35 (3).

²³⁶Mental Health Act, R.S.O. 1990, c. M.7, s. 36 (1).

²³⁷Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 40 (1).

²³⁸Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 57 (1). S. 1 of the Act states:

“personal assistance service” means assistance with or supervision of hygiene, washing, dressing, grooming, eating, drinking, elimination, ambulation, positioning or any other routine activity of living, and includes a group of personal assistance services or a plan setting out personal assistance services to be provided to a person, but does not include anything prescribed by the regulations as not constituting a personal assistance service.

A) **Health Care Consent Act, 1996**²³⁹

a) **Treatment Capable Patients**

“Capacity” is defined in s. 4 (1) of the Health Care Consent Act, 1996:

A person is capable with respect to a treatment, admission to a care facility or a personal assistance service if the person is able to understand the information that is relevant to making a decision about the treatment, admission or personal assistance service, as the case may be, and able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

A person is presumed to be capable unless there is “... reasonable cause to believe otherwise”.²⁴⁰ By extension of the definition of “capacity” set out in s. 4 of the Act, a person will be found incapable of making treatment decisions if she cannot understand or appreciate the reasonably foreseeable consequences of giving or refusing consent.

If a person is capable, consent must be obtained from him to proceed with

²³⁹S.O. 1996, c. 2, Sch. A.

²⁴⁰Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A., s. 4 (2) and (3) states:

(2) **Presumption of capacity.**--A person is presumed to be capable with respect to treatment, admission to a care facility and personal assistance services.

(3) **Exception.**--A person is entitled to rely on the presumption of capacity with respect to another person unless he or she has reasonable grounds to believe that the other person is incapable with respect to the treatment, the admission or the personal assistance service, as the case may be.

treatment.²⁴¹ For such consent to be valid it must be informed.²⁴² A “blanket” assessment of capacity does not exist: capacity is decision specific.²⁴³ Consent may be withdrawn at any time.²⁴⁴

²⁴¹See common law emergency exceptions at p. 73.

²⁴²Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 11 states:

(1) Elements of Consent.--The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud.

(2) Informed consent.--A consent to treatment is informed if, before giving it,

- (a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and
- (b) the person received responses to his or her requests for additional information about those matters.

(3) Same.--The matters referred in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment.

(4) Express or implied.--Consent to treatment may be express or implied.

²⁴³Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A., s. 15 (1) and (2) state:

(1) **Capacity depends on treatment.**--A person may be incapable with respect to some treatments and capable with respect to others.

(2) **Capacity depends on time.**--A person may be incapable with respect to a treatment at one time and capable at another.

²⁴⁴Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 14 states:

Withdrawal of consent.--A consent that has been given by or on behalf of

b) Treatment Incapable Patients

In the event a person is found incapable of making decisions regarding treatment, a substitute decision-maker must be approached for consent.²⁴⁵ The term substitute decision-maker [often referred to as SDM] is defined in the Health Care Consent Act, 1996 in s. 9:²⁴⁶

Meaning of “substitute decision-maker”.--In this Part, “substitute decision-maker” means a person who is authorized under section 20 to give or refuse consent to a treatment on behalf of a person who is incapable with respect to the treatment.

The Health Care Consent Act, 1996²⁴⁷ lists those persons who may act in this capacity in s. 20 (1). It should be noted that this list is hierarchical in nature: the person highest up on the list is to be approached first to provide substitute

the person for whom the treatment was proposed may be withdrawn at any time,

- (a) by the person, if the person is capable with respect to the treatment at the time of the withdrawal;
- (b) by the person’s substitute decision-maker, if the person is incapable with respect to the treatment at the time of the withdrawal.

²⁴⁵Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A., s. 10 (1) (b). Exceptions to the requirement for consent will be discussed further at p 73. It should be noted that a person who disagrees with the finding of a physician that he or she is incapable of making treatment decisions may appeal such a finding to the Consent and Capacity Board (s. 32 (1)).

²⁴⁶S.O. 1996, c. 2, Sch. A.

²⁴⁷S.O. 1996, c. 2, Sch. A.

consent.²⁴⁸ A substitute decision-maker (hereinafter SDM) must meet certain requirements as set out in s. 20 (2):

Requirements--A person described in subsection (1) may give or refuse consent only if he or she,

- (a) is capable with respect to the treatment;
- (b) is at least 16 years old, unless he or she is the incapable person's parent;
- (c) is not prohibited by court order or separation agreement from having access to the incapable person or giving or refusing consent on his or her behalf;
- (d) is available; and
- (e) is willing to assume the responsibility of giving or refusing consent.²⁴⁹

The substitute decision-maker must make an informed choice as set out in s. 11 of the Act. In order to make such a decision for an incapable person, the SDM must be provided with all necessary information.²⁵⁰

Any decision made by a substitute decision-maker on behalf of a treatment incapable person must be made according to any express wishes the incapable

²⁴⁸Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 20 (30).

²⁴⁹Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A.

²⁵⁰Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 22 states:
Information.--Before giving or refusing consent to a treatment on an incapable person's behalf, a substitute decision-maker is entitled to receive all the information required for an informed consent as described in subsection 11 (2).

person made known while capable and over the age of 16.²⁵¹ In the event such wishes are not known, or they cannot be complied with, a decision should be made following the best interests criteria set out in s. 21 (2).

The question that arises at this point, given that the focus in this thesis is on involuntary treatment of voluntary patients, is what constitutes treatment--can a substitute decision-maker consent to the actions necessary to deliver treatment to a voluntary, treatment incapable patient (e.g. physical restraint)?

c) **Definition of treatment**

Section 2 (1) of the Health Care Consent Act, 1996 defines "treatment":

"treatment" means anything that is done for a therapeutic, preventive, palliative, diagnostic, cosmetic or other health-related purpose, and includes a course of treatment or plan of treatment, but does not include,

- (a) the assessment for the purpose of this Act of a person's capacity with respect to a treatment, admission to a care facility or a personal assistance service, the assessment for the purpose of the *Substitute Decisions Act, 1992* of a person's capacity to manage property or a person's capacity for personal care, or the assessment of a person's capacity for any other purpose,
- (b) the assessment or examination of a person to determine the general nature of the person's condition,
- (c) the taking of a person's health history,
- (d) the communication of an assessment or diagnosis,
- (e) the admission of a person to a hospital or other facility,

²⁵¹Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 21 (1).

- (f) a personal assistance service,
- (g) a treatment that in the circumstances poses little or no risk of harm to the person,
- (h) anything prescribed by the regulations as not constituting treatment.

It might be argued that the phrase “anything done for a therapeutic purpose” in the definition in s. 2 (1) could include the actual physical restraint by the members of the health care team that is necessary in order to administer medication ordered by the physician, and consented to by a substitute decision-maker with appropriate authority, to treat an incapable patient. It could also be argued that it includes any mechanical restraint necessary to administer such treatment as electroconvulsive therapy (e.g. restraint to a stretcher). However, I would argue against such a broad interpretation. For the period that the incapable person is physically restrained by nurses to be given a needle, or restrained to a stretcher while having electroconvulsive therapy administered, she is unable to leave the facility. Her voluntary status, during that time, becomes, in actual fact, a nullity. Reading treatment broadly blurs the committal -involuntary treatment distinction that has been at the heart of law reform in this area for decades²⁵² and is, indeed, reflected

²⁵²As noted in Chapter 1, the law in Ontario of years past did not separate criteria for commitment from decisions regarding consent to treatment. Once a person was admitted to a psychiatric facility, treatment was given. The Mental Health Act, 1967 separated criteria for involuntary commitment from the issue of treatment. The courts have recognized that capable persons have the right to refuse treatment and incapable persons in psychiatric facilities must have their

in the clear statement in this section of the Act to the effect that treatment does not include admission to a hospital or other facility.²⁵³

d) Exception to Consent Requirement

The Health Care Consent Act, 1996 sets out that consent does not have to be obtained from another on the behalf of an incapable person in the event of an emergency.²⁵⁴ Section 25 (2) states:

Emergency treatment without consent: incapable person.--

Despite section 10, a treatment may be administered without consent to a person who is incapable with respect to the treatment, if, in the opinion of the health practitioner proposing the treatment,

- (a) there is an emergency; and
- (b) the delay required to obtain a consent or refusal on the person's behalf will prolong the suffering that the person is apparently experiencing or will put the person at risk of sustaining serious bodily harm.²⁵⁵

prior capable wishes honoured, even if that results in no treatment for psychiatric symptoms. If the Health Care Consent Act, 1996 definition of treatment included the authority to detain an incapable person to a psychiatric facility, the law would have regressed to the point it was pre 1967, taking the hard-fought victories for and by persons with mental illnesses with it.

²⁵³Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 2 (1) (e).

²⁵⁴“Emergency” is defined in s. 25 (1) of the Health Care Consent Act, 1996 as:
Meaning of “emergency”--For the purpose of this section and section 27, there is an emergency if the person for whom the treatment is proposed is apparently experiencing severe suffering or is at risk, if the treatment is not administered promptly, of sustaining serious bodily harm.

²⁵⁵Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 25 (2).

The authority to restrain a person in an emergency is found in the Health Care Consent Act, 1996 in s. 7:

Restraint, confinement.--This Act does not affect the common law duty of a caregiver to restrain or confine a person when immediate action is necessary to prevent serious bodily harm to the person or to others.

Therefore, in an emergency a person can be treated without consent,²⁵⁶ and restraint can be used to deliver such emergency treatment.²⁵⁷

To sum up, voluntary, treatment incapable patients cannot be restrained for the purposes of treatment, except for in emergency situations, under the authority of the Health Care Consent Act, 1996. I now turn to a review of the other Acts to see if a different position can be supported on the basis of that legislation.

B) Substitute Decisions Act, 1992²⁵⁸

Incapacity for personal care is defined in s. 45 of the Act:

A person is incapable of personal care if the person is not able to understand information that is relevant to making a decision concerning his or her own health care, nutrition, shelter, clothing, hygiene or safety, or is not able to appreciate the reasonably foreseeable consequences of a decision or lack of decision.

²⁵⁶Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 25 (2).

²⁵⁷Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 7.

²⁵⁸S.O. 1992, c. 30.

A person who is incapable of making treatment decisions must have those decisions made by another. In order to prepare for a future period of incapacity, an individual may execute a Power of Attorney for Personal Care ("POAPC"). Many people have not executed such a document. Therefore, it is important to review the scope of decisions that can be made by another on the behalf of a treatment incapable person where a POAPC exists, and where one does not.

a) Power of Attorney for Personal Care Exists

A POAPC allows a named person to exercise decision making power should the grantor become incapable of making treatment decisions.²⁵⁹ Any decision that is explicitly authorized in the POAPC may be consented to by the named attorney.

A person may be given the authority in a Power of Attorney for Personal Care to force treatment on the incapable person. S. 50 (2) (2) states:

A provision that authorizes the attorney and other persons under the direction of the attorney to use force that is necessary and reasonable in the circumstances to take the grantor to that place and to detain and restrain the grantor in that place during the care or treatment.²⁶⁰

Should such an incapable, voluntary person resist treatment, the authority provided in the Power of Attorney for Personal Care would be sufficient for

²⁵⁹Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 46 (1).

²⁶⁰Substitute Decisions Act, 1992, S.O. 1992, c. 30.

members of the health care team to restrain the person in order to administer treatment, even over his or her objection. While it is true that the voluntary patient would then be prevented from leaving the facility during those times of restraint, this detention is legal since the named person exercising authority under the Power of Attorney for Personal Care also has the authority to consent to the detention of the person. It should be remembered that authority originated in the first place with the person who is now incapable, when he executed such a directive while capable. The person acting as his substitute is following explicit instructions of the person who is now incapable.

If there is no specific provision in the Power of Attorney for Personal Care for the named individual to have the now incapable person admitted, restrained and detained for the purposes of treatment, the substitute decision-maker can still attempt to have the person admitted to a psychiatric facility. However, if the person is 16 years of age or older, objects, and is voluntary the admission cannot be forced.²⁶¹ Even if the person did not object to the admission to the psychiatric facility, I would argue that treatment could not be forced for the reasons given in the Section on the Health Care Consent Act, 1996.²⁶²

²⁶¹Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 24.

²⁶²See p. 71-73.

Where a POAPC explicitly does not give the authority for another to consent to restraint for the purposes of treatment, it is clear that the substitute decision-maker could not provide such consent in the event of a future period of incapacity.

b) Where No Power of Attorney for Personal Care Exists

The Substitute Decisions Act, 1992 also sets out provisions for the appointment of a guardian by the Court, as set out earlier in this Chapter.²⁶³ The Court may appoint a guardian with powers to make decisions regarding health care if the person is incapable of making such decisions and has not executed a POAPC.²⁶⁴ A full guardianship order would enable the guardian to make decisions regarding where the person resided,²⁶⁵ in relation to any matter to which the Health Care Consent Act, 1996 applied,²⁶⁶ regarding the person's health care, nutrition and hygiene,²⁶⁷ and any other powers specified in the court Order.²⁶⁸ The authority of a person who has full guardianship over another may arguably be sufficient to allow for restraint for the purposes of treatment since the person may make

²⁶³See pages 57-61.

²⁶⁴Substitute Decisions Act, 1992, S.O. 1992, c. 30, ss. 59 or 60.

²⁶⁵Ibid. at s. 59 (2) (a).

²⁶⁶Ibid. at s. 59 (2) (e).

²⁶⁷Ibid. at s. 59 (2) (e.1).

²⁶⁸Ibid. at s. 59 (2) (g).

decisions regarding where the person resides.

A person may be granted partial guardianship over another.²⁶⁹ The authority of such a person would be granted expressly in the Court Order.²⁷⁰ Therefore, if authority was granted to make decisions regarding health care and residence, an incapable person could be detained at a psychiatric facility and given treatment consented to by his guardian, even if restraint was required to administer such treatment. However, if the Order pertained only to the authority to make decisions regarding health care, the authority to have a voluntary, incapable person restrained for the purposes of treatment would arguably not be conveyed by the Order. Specific authority to detain and/or restrain would be required in the Order.

C) **Mental Health Act**²⁷¹

The **Mental Health Act**²⁷² states:

[n]othing in this Act authorizes a psychiatric facility to detain or

²⁶⁹**Substitute Decisions Act, 1992**, S.O. 1992, c. 30, s. 60.

²⁷⁰**Substitute Decisions Act, 1992**, S.O. 1992, c. 30, s. 60 (3).

²⁷¹R.S.O. 1990, c. M.7.

²⁷²R.S.O. 1990, c. M.7.

restrain an informal or voluntary patient.²⁷³

As has just been reviewed, the Health Care Consent Act, 1996 and the Substitute Decisions Act, 1992 provide that authority in some circumstances.

The Mental Health Act²⁷⁴ does define “substitute decision-maker” in s. 1:

“substitute decision-maker”, in relation to a patient, means the person who would be authorized under the Health Care Consent Act, 1996 to give or refuse consent to a treatment on behalf of the patient, if the patient were incapable with respect to the treatment under that Act....

With the passage of the Health Care Consent Act, 1996²⁷⁵ and the Substitute Decisions Act, 1992,²⁷⁶ the legislative guidelines regarding consent to treatment, and specifically involuntary treatment, were removed from the Mental Health Act.²⁷⁷ However, the Mental Health Act remains relevant as it stipulates that psychosurgery cannot be performed on an incapable person, even with the consent

²⁷³Mental Health Act, R.S.O., c. M.7, s. 14. However, as explicitly enunciated in both the Health Care Consent Act, 1996, and Substitute Decisions Act, 1992, this prohibition against restraining persons does not affect the common law duty of caregivers to restrain or confine persons in order to prevent serious bodily harm to the patient, or to others. See 55 and 63.

²⁷⁴R.S.O. 1990, c. M.7.

²⁷⁵R.S.O. 1996, c. 2, Sch. A.

²⁷⁶S.O. 1992, c. 30.

²⁷⁷R.S.O. 1990, c. M.7.

of his or her substitute decision-maker.²⁷⁸ Section 49 (1) states:

Psychosurgery.--Psychosurgery shall not be administered to an involuntary patient, to a person who is incapable of giving or refusing consent to psychosurgery on his or her own behalf for the purpose of the *Health Care Consent Act, 1996*, or to a person who is remanded or detained in a psychiatric facility pursuant to the *Criminal Code (Canada)*. 1987, c. 37, s. 11; 1992, c. 32, s. 20 (39); 1996, c. 2, s. 72 (30).

D) Common Law Applicable to Treatment

a) no treatment is to be given without consent

It has been a longstanding principle of Canadian law that anyone providing treatment, absent consent, or an exception to the consent rule,²⁷⁹ will be liable for

²⁷⁸Mental Health Act, R.S.O. 1990, c. M.7, s. 49. It should be noted that s. 49 (2) stipulates that psychosurgery for the treatment of neurological disorders is not included in the prohibitions in s. 49 (1).

²⁷⁹There are exceptions made for emergency situations: see Malette v. Shulman (1990), 72 O.R. (2d) 417 (C.A.) where Justice Robins states:

The emergency situation is an exception to the general rule requiring a patient's prior consent. When immediate medical treatment is necessary to save the life or preserve the health of a person who, by reason of unconsciousness or extreme illness, is incapable of either giving or withholding consent, the doctor may proceed without the patient's consent. The delivery of medical services is rendered lawful in such circumstances either on the rationale that the doctor has implied consent from the patient to the emergency aid, or more accurately in my view, on the rationale that the doctor is privileged by reason of necessity in giving the aid and is not to be held liable for so doing.

an action in battery.²⁸⁰ Deficiencies in the consent process (e.g. a lack of adequate information on which to make an informed choice) which result in harm to the patient may result in health care personnel being liable in negligence.²⁸¹

This common law principle was considered in the psychiatric treatment context in Fleming v. Reid.²⁸² The Mental Health Act²⁸³ contained a provision that allowed that the prior capable wishes of an involuntarily detained, incapable person could be overridden on application by a physician to the Review Board.²⁸⁴ S. 35 (2) stated:

- Psychiatric and other related medical treatment shall not be given to a patient,
- (a) where the patient is mentally competent, without the voluntary, informed consent of the patient;
 - (b) where the patient is not mentally competent,
 - (i) without the consent of a person authorized by section 1 (a) to consent on behalf of the patient,
 - (ii) unless the review board has made an order authorizing the giving of the specified psychiatric or other related medical treatment, or
 - (iii) unless a physician certifies in writing that there is

²⁸⁰Reibl v. Hughes (1980), 114 D.L.R. (3d) 1 at 8-11 (S.C.C.) (hereinafter Reibl), Malette, *supra* note 279.

²⁸¹Reibl, *supra* note 280 at 10-11, Ciarlariello v. Schacter, [1993] 2 S.C.R. 119, 100 D.L.R. (4th) 609 at 617 (cited to D.L.R.) (hereinafter Ciarlariello).

²⁸²Fleming, *supra* note 65.

²⁸³R.S.O. 1980, c. 262.

²⁸⁴Mental Health Act, R.S.O. 1980, c. 262, s. 35(2) (b) (ii).

imminent and serious danger to the life, a limb or a vital organ of the patient requiring immediate treatment and the physician believes that delay in obtaining consent would endanger the life, limb or a vital organ of the patient.

Two patients held involuntarily and deemed incapable to consent to treatment at Penetanguishene Mental Health Centre had, when previously capable, made their wishes not to be treated with psychotropic medications known. The Official Guardian was appointed to act as these men's decision-maker. Following their prior known capable wishes, as directed by the Act, the Official Guardian refused to consent to treatment with antipsychotics. The physician applied to the Board for treatment permission as set out in s. 35 (2) of the Act. The Official Guardian challenged the constitutionality of this provision of the Mental Health Act.²⁸⁵

Although the two men, represented by the Official Guardian, were unsuccessful at trial, the decision was overturned by the Ontario Court of Appeal. In its reasons, the Court explicitly reinforced the common law principle that no treatment was to proceed without the consent of a capable person or his or her decision-maker:

The right to determine what shall, or shall not be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exception, every person's body is considered inviolate, and, accordingly, every

²⁸⁵R.S.O. 1980, c. 262.

competent adult has the right to be free from unwanted treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination.²⁸⁶

Since the Mental Health Act had legislated that the prior known capable wishes of a now incapable person must be followed,²⁸⁷ it could not also include provisions in the Act to “...render those competent wishes, and the substitute’s decisions based thereon, entirely meaningless when a treatment order is sought from the review board.”²⁸⁸

The Court of Appeal held that the provisions of the Mental Health Act²⁸⁹ authorizing that an involuntary treatment incapable person’s prior capable wishes could be overruled by an order of the Review Board violated s.7 of the Canadian Charter of Rights and Freedoms²⁹⁰ and could not be saved by s. 1.

²⁸⁶Fleming, supra note 65 at 85.

²⁸⁷Mental Health Act, R.S.O. 1980, c. 262, s. 1 (a) (6).

²⁸⁸Fleming, supra note 65 at 93.

²⁸⁹R.S.O. 1990, c. M.7.

²⁹⁰Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

b) consent must be informed

The Supreme Court in Hopp v. Lepp²⁹¹ held that in order to provide informed consent, a patient should be advised of the nature of the procedure to be performed, any material risks, and any risks that might be specifically important to the particular patient.²⁹² The Court also recognized that the physician should answer any questions that the patient specifically put forward.²⁹³ These requirements attempt to balance the rights of persons to be informed while not imposing an arguably impossible burden on physicians to disclose every side effect of a proposed treatment that has ever been reported.

Reibl v. Hughes,²⁹⁴ decided shortly after Hopp v. Lepp²⁹⁵ by the S.C.C. reinforced the principle that any material risks and risks that might be of particular significance to the patient must be disclosed by the physician. In addition, the Court adopted a modified objective test in relation to causation:

...other aspects of the objective standard would have to be geared to what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all

²⁹¹[1980] 2 S.C.R. 192, 112 D.L.R. (3d) 67 (cited to D.L.R.) (hereinafter Hopp).

²⁹²Hopp, supra note 291 at 81.

²⁹³Ibid.

²⁹⁴Supra, note 280.

²⁹⁵Hopp, supra note 291.

material and special risks of going ahead with the surgery or foregoing it were made known to him.

.....
In short, although account must be taken of a patient's particular position, a position that will vary with the patient, it must be objectively assessed in terms of reasonableness.²⁹⁶

Recently the Supreme Court of Canada reiterated the principles regarding informed consent set out in Hopp v. Lepp²⁹⁷ and Reibl v. Hughes.²⁹⁸ In Arndt v. Smith²⁹⁹ Justice Cory reviewed the importance of recognizing informed consent:

Reibl v. Hughes is a very significant and leading authority. It marks the rejection of the paternalistic approach to determining how much information should be given to patients. It emphasizes the patient's right to know and ensures that patients will have the benefit of a high standard of disclosure.

.....
The Reibl v. Hughes test has had the desired effect of ensuring that patients have all the requisite information to make an informed decision regarding the medical procedures they are contemplating.³⁰⁰

c) consent may be withdrawn at any time

The Supreme Court of Canada in Ciarlariello v. Schacter³⁰¹ explicitly reinforced

²⁹⁶Reibl, supra note 280 at 16-17.

²⁹⁷Supra, note 291.

²⁹⁸Supra, note 280.

²⁹⁹(1997), 148 D.L.R. (4th) 48 (S.C.C.) (hereinafter Arndt).

³⁰⁰Ibid. at 56.

³⁰¹Ciarlariello, supra note 281.

that consent, once given, may be withdrawn. Justice Cory considered this principle in light of the fundamental right of a person to control her own body:

It should not be forgotten that every patient has a right to bodily integrity. This encompasses the right to determine what medical procedures will be accepted and the extent to which they will be accepted. Everyone has the right to decide what is to be done to one's own body. This includes the right to be free from medical treatment to which the individual does not consent. This concept of individual autonomy is fundamental to the common law and is the basis for the requirement that disclosure be made to a patient. If during the course of a medical procedure a patient withdraws the consent to that procedure, then the doctor must halt the process. This duty to stop does no more than recognize every individual's basic right to make decisions concerning his or her own body.³⁰²

- d) **capable means possessing the ability to understand information and appreciate the consequences of a decision or lack of a decision**

Howlett v. Karunaratne³⁰³ set out the three elements required for proof of mental capacity to consent to treatment:

To be “mentally competent” a person must:

- (1) Have the ability to understand the nature of the illness for which treatment is proposed; *and*
- (2) Have the ability to understand the treatment proposed, *and*
- (3) Be able to appreciate the consequences of giving or

³⁰²Ciarlariello, *supra* note 281 at 618-19. The Court did acknowledge that halting some procedures midway through their course might result in life threatening or serious problems for the patient. In these circumstances, a doctor might be justified in continuing. The Court also recognized that a determination of whether a person was capable at the time of withdrawing consent would have to be made.

³⁰³(1988), 64 O.R. (2d) 418 (Dist. Ct.) (hereinafter Howlett).

withholding consent.³⁰⁴

These requirements were adopted by successive Ontario courts in McKay v. O'Doherty,³⁰⁵ Tran v. Ralyea,³⁰⁶ Taylor v. Penetanguishene Mental Health Centre,³⁰⁷ and Khan v. St. Thomas Psychiatric Hospital.³⁰⁸ In McKay the Court recognized that because of the patient's intelligence and her familiarity with mental illness that came from witnessing the experiences of her mother, she was able to recite information regarding mental illness and proposed treatments without difficulty. However, because she did not believe she was ill, and this denial formed part of her mental illness, the Court ruled that she was incapable to make treatment decisions: she could not apply her knowledge regarding mental illness and treatment options to herself.³⁰⁹ This requirement that the person must acknowledge the presence of a mental illness and be able to apply the knowledge of proposed treatment or lack of treatment to himself or herself has been adopted

³⁰⁴Howlett, *supra* note 303 at 421-22.

³⁰⁵McKay, *supra* note 152.

³⁰⁶Tran, *supra* note 165.

³⁰⁷[1993], O.J. No. 3090 (C.J. (Gen. Div.)) (Q.L.) (hereinafter Taylor).

³⁰⁸(1992), 7 O.R. (3d) 303 (hereinafter Khan).

³⁰⁹McKay, *supra* note 152 at 23-24.

by the courts in Tran,³¹⁰ Taylor,³¹¹ and Khan.³¹²

e) involuntary hospitalization and incapacity are not synonymous

Justice Robins in Fleming v. Reid³¹³ acknowledged that “[t]he determination of a patient as voluntary or involuntary is independent of any assessment of a patient’s mental competency.”³¹⁴ He went on to state that:

...involuntary patients, including those who, like the appellants, are being held pursuant to the Criminal Code, are taken to have the capacity to decide for themselves whether or not to receive anti-psychotic drugs. Until they are found incompetent, they hold the same rights as any other competent patients in the facility. Indeed, they hold the same rights as competent persons elsewhere in the province whose consent must be obtained before they can be the subject of medical treatment. Mentally ill persons are not to be stigmatized because of the nature of their illness or disability; nor should they be treated as persons of lesser status or dignity. Their right to personal autonomy and self-determination is no less significant, and is entitled to no less protection, than that of competent persons suffering from physical ailments.³¹⁵

³¹⁰Tran, supra note 165 at para. 14.

³¹¹Taylor, supra note 307 at para. 11.

³¹²Khan, supra note 308 at 315.

³¹³Fleming, supra note 65.

³¹⁴Ibid. at 78.

³¹⁵Ibid. at 86-87.

III. The Interaction Between Commitment Status and a Finding of Incapacity to Consent to Treatment

Commitment status and incapacity to consent to treatment are two entirely different matters. A person can be an informal, voluntary, or involuntary patient in a psychiatric facility.³¹⁶ Persons are either capable or incapable of making treatment decisions. The Mental Health Act, 1967³¹⁷ separated the criteria necessary for involuntary admission and enquiries regarding treatment for the first time. Successive mental health legislation and interpretation by the judiciary has continued to delineate this separation. However, a patient's commitment status and his capacity to consent to treatment do have incidental connections important in determining whether treatment can be forced, even with valid consent from a substitute decision-maker.

There are four categories of patients who may be resident in a psychiatric facility:

- 1) involuntarily committed and capable of making treatment decisions;
- 2) voluntary and capable of making treatment decisions;
- 3) involuntarily committed and incapable of making treatment decisions; and
- 4) voluntary and incapable of making treatment decisions.

The law is clear regarding what must happen (or not happen) with respect to the first two categories of persons who refuse treatment. The law is not clear

³¹⁶It should be noted that a person may also be detained under the Criminal Code in a psychiatric facility but this situation will not be addressed in this thesis.

³¹⁷S.O. 1967, c. 51.

regarding the third and fourth categories. In order to understand what effect a patient's commitment status and capacity to consent to treatment may have on the ability to force treatment, all combinations of capacity/incapacity and voluntary/involuntary scenarios will be reviewed.

A) involuntary and capable of making treatment decisions

This principle was set out clearly in Fleming v. Reid.³¹⁸ If an involuntary, capable patient, refusing treatment, continues to meet the criteria for involuntary committal, he must be detained. He cannot, however, be forcibly treated. Many people, including psychiatrists like Dr. A.D. Milliken, find this situation intolerable:

As a clinician I do not wish to be associated with restraint or incarceration without any form of treatment. To confine someone against their wishes because they are ill and yet not be able to provide the treatment which I know will be beneficial can only be described as repugnant. I believe that the majority of society would equally regard it so.³¹⁹

However, no matter what the majority of society, or Dr. Milliken, thinks, the law is clear that those capable of making treatment decisions must have those decisions respected.

³¹⁸Fleming, *supra* note 65.

³¹⁹Charles Pearson, "Consent to Psychiatric Treatment in Canada--Specific Issues" 2:2 Health Law Review 3 at 14, citing Dr. A.D. Milliken, "The Uniform Mental Health Act: A Clinician's Questions" (1987) 7 Health L. Can. 76 at 82.

B) voluntary and capable of making treatment decisions

A capable person is one whose decisions regarding treatment must be respected.³²⁰

He may accept or refuse treatment. A voluntary patient must be discharged on request.³²¹ In the event that such a person disagreed with the treatment proposed by the physician, she could leave hospital or seek to remain in hospital, but refuse treatment. Involuntary treatment of a capable person is outside the law.

C) involuntary and incapable of making treatment decisions

For treatment incapable persons, consent must be obtained from a substitute decision-maker. If consent is obtained, and the patient then resists, for example, to take his medications as ordered by mouth,³²² they could be given by injection, using restraint if necessary. This may be justified because consent has been obtained for the treatment, and the restraint does not affect the person's ability to

³²⁰Reibl, supra note 280.

³²¹As noted earlier, although voluntary persons may ask to be discharged, many hospitals have policies that dictate that any person asking for discharge must be interviewed by a physician. In the event the physician finds that the person meets the criteria for commitment, the physician may certify him under s. 20 (5).

³²²It should be noted that I am making several assumptions here in my illustration: the consent must be informed, the substitute decision-maker must be the person entitled to give or refuse consent, and the necessary and appropriate orders must have been obtained from the physician to give the medications by mouth, or, if refused, by injection. Some medications, such as Lithium Carbonate (used in the treatment of manic depression) and anti-depressants are not manufactured in injection form and therefore, this scenario does not even arise.

ask for her discharge: she is already being detained under the authority of the Mental Health Act.³²³ The question is, however, outside of the scope of this thesis and I take no position on this matter. It is an untested area of the law.

D) voluntary and incapable of making treatment decisions

According to the law in Ontario as it now stands, when a voluntary patient, who is treatment incapable refuses to comply with treatment, restraint for the purposes of treatment is permissible if:

- a) a Power of Attorney for Personal Care exists with specific authority to restrain and detain; or
- b) no POAPC exists but the substitute decision-maker has a full guardianship order from the court; or
- c) no POAPC exists but the substitute decision-maker has a partial guardianship order from the court with specific authority to restrain and detain.

If neither a), b) or c) exist, it is not permissible to restrain a voluntary patient for the purposes of treatment. Therefore, there will be some instances when treatment, ordered by a physician and consented to by a substitute decision-maker, cannot be administered to a voluntary, treatment incapable patient.

Conclusion

The law regarding psychiatric hospitalization and capacity to make treatment

³²³R.S.O. 1990, c. M.7.

decisions in Ontario is modelled on a dangerousness standard for committal and a moderately liberal approach to capacity determination. Under the current legislative scheme, a voluntary, treatment incapable patient cannot be restrained for the purposes of treatment that has been ordered by her physician and consented to by a substitute decision-maker, absent authority contained in a Power of Attorney for Personal Care or a Guardianship Order . The existence of such Powers of Attorney for Personal Care, or Guardianship Orders, are not common.³²⁴ Therefore, the perplexing situation can arise in which a voluntary patient deemed incapable of making treatment decisions cannot be provided with treatment considered to be in the best interests of the patient by both the health care team and the patient's surrogate decision-maker. This is a situation resulting from the current state of the law. The question that must now be addressed is whether the state of the law is acceptable. Have we found the right balance between promoting the well-being of mentally ill individuals and protecting their rights, or have we, in seeking to distance ourselves from the abuses of the past, tilted too far in the direction of rights at too great a cost for well-being?

³²⁴I am making this statement based on my experience as a Registered Nurse on an Acute Admitting Ward in a Provincial Psychiatric Hospital. In my 13 years of practice I have never seen a patient admitted or treated under either of these two routes.

CHAPTER 3--ETHICAL AND POLICY CONSIDERATIONS

Introduction

From the review of the current status of the law in Ontario regarding the ability to force treatment on a voluntary, treatment incapable person that was carried out in Chapter 2, I believe that, absent a guardianship order with appropriate authority or a Power of Attorney for Personal Care with a Ulysses type clause, the restraint and subsequent detention of a voluntary, treatment incapable person is illegal.

Others may disagree with my interpretation of the law. However, it is at the very least, a fair statement that the law in this regard is not settled and my research has not located a single Canadian judgment on this issue.

Proceeding on my belief that the restraint and incidental detention of a voluntary, treatment incapable person, absent the exceptions listed above and discussed in Chapter 2, is illegal, an analysis of whether or not the law should permit the involuntary treatment of a voluntary patient will now be undertaken. In this Chapter I will set out arguments for and against permitting the involuntary treatment of voluntary patients.³²⁵ In each instance, I will first set out the argument

³²⁵It should be noted that throughout this Chapter I will be referring to the “involuntary treatment of voluntary, incapable persons”. In doing so I am speaking of the group of persons who cannot be involuntarily treated, even despite substitute consent. Persons with guardianship orders or Powers of Attorney for Personal Care with a Ulysses

in the voice of those who would endorse the argument and then, under the heading “Considerations”, assess the argument.

I. ARGUMENTS FOR PERMITTING THE INVOLUNTARY TREATMENT OF VOLUNTARY, TREATMENT INCAPABLE PERSONS

A) The Law in Ontario Recognizes that Incapable Persons Need Decisions Made for Them

The present law in Ontario has set out an elaborate scheme whereby a person unable to make decisions regarding her treatment must have someone else consent on her behalf. This scheme is based on two fundamental beliefs. First, in law no beneficial treatment is to proceed or be withheld without a valid consent.³²⁶ A valid consent or refusal is understood as a free and informed consent or refusal given by a person who understands the nature and significance of the decision being made. Second, an incapable person may not appreciate the consequences of giving or refusing consent.³²⁷ If he does not understand, his refusal of treatment can prevent treatment and, in effect, an invalid refusal is being respected. If a treatment incapable person’s refusal of treatment is respected, then a decision is being made by someone who may not be capable of understanding the nature

type clause are not included in this group.

³²⁶There are of course exceptions for emergency treatment. See p. 73.

³²⁷Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 4 (1).

and consequences of the decision. This flies in the face of contemporary informed consent theory.

Considerations

This argument blurs the distinction between confinement and treatment.

Contemporary informed consent theory concerns itself with treatment, not confinement. The standard for hospitalization is dangerousness, not competence. Under current law, the voluntary patient can walk out of the hospital. To permit blocking passage out of the hospital would be to erase the distinction between committal and treatment. Clearly, leaving the hospital would be exercising a choice that would preclude treatment.

B) Young children, who are incapable of making treatment decisions, are restrained by parents routinely in order to receive treatment

Many a parent has physically restrained a young child in order for procedures such as booster shots, and medication to be administered to an unwilling, fearful child. It is extremely unlikely that such restraint would be considered illegal. By analogy, the restraint of mentally ill adults for the purposes of treatment should be legally permitted (assuming valid consent has been given by a substitute decision-maker).

Considerations

It is true that parents often restrain young children who are afraid of needles or who do not wish to take medications such as antibiotics. They obviously ought to have their decisions re medication respected. But what about the decisions regarding restraint?

As pointed out in Chapter 2, it is my belief that any restraint that is incidental to the delivery of a treatment that has been consented to by a substitute decision-maker for a treatment incapable person can be considered part of the treatment. The definition of “treatment” in s. 2 (1) of the Health Care Consent Act, 1996³²⁸ is broad enough to include restraint. However, the difficulty arises in that the restraint, although part of the treatment, results in an incidental detention of a voluntary patient. Unless the substitute decision-maker has the authority also to consent to the detention of the incapable person for the purposes of treatment, such restraint is, in my belief, illegal.³²⁹

However, the treatment and restraint of children for the purposes of treatment can be distinguished from the treatment and restraint of the mentally ill . The common

³²⁸S.O. 1996, c. 2, Sch. A.

³²⁹See p. 92 for a summary of substitute decision-makers with authority to consent to the detention of a treatment incapable person for the purposes of treatment.

law recognizes that parents are responsible for the care and custody of their children. In B.(R.) v. Children's Aid Society of Metropolitan Toronto³³⁰ the Supreme Court of Canada recognized the constitutional rights of parents to make decisions for children who are in their custody. Justice LaForest stated:

...I would have thought it plain that the right to nurture a child, to care for its development, and to make decisions for it in fundamental matters such as medical care, are part of the liberty interest of a parent. As observed by Dickson J. in *R. v. Big M Drug Mart Ltd.*, *supra*, the Charter was not enacted in a vacuum or absent a historical context. The common law has long recognized that parents are in the best position to take care of their children and make all the decisions necessary to ensure their well-being.

.....
 ..In recent years, courts have expressed some reluctance to interfere with parental rights, and state intervention has been tolerated only when necessity was demonstrated. This only serves to confirm that the parental interest in bringing up, nurturing and caring for a child, including medical care and moral upbringing, is an individual interest of fundamental importance to our society.³³¹ [emphasis added]

Parents may restrain their children in order to, for example, have them immunized as such action can be characterized as in the best interests of the child. There is no liberty issue at stake. However, within the context of treatment of persons with mental illnesses, there is a liberty interest that should not be discounted. In fact,

³³⁰[1995], 122 D.L.R. (4th) 1.

³³¹B.(R.) v. Children's Aid Society of Metropolitan Toronto, *supra* note 360 at 40-41. See also: Benoit v. Benoit (1972), 6 R.F.L. 180 (Ont. Prov. Ct.); Kruger v. Kruger (1979), 25 O.R. (2d) 673 (Prov. Ct.); and Ontario Department of Justice, Ministry of Supply and Services, "Custody and Access: Public Discussion" (Toronto: Queen's Printer, 1974) at 7.

the legislation explicitly separates committal and treatment issues recognizing this distinction. There is no provision for the substitute decision-maker of a treatment incapable person to make "all decisions necessary" as recognized by the common law in terms of parental power.

C) Assistance of Person to Potentially Achieve Optimal Quality of Life

Many persons with mental illnesses function very well in society. Often a part of this success can be attributed to treatments used to control mental illnesses. A voluntary, treatment incapable person who refuses to comply with a course of treatment consented to by her decision-maker may be deprived of the opportunity to achieve optimal wellness if involuntary treatment is not given.

Considerations

While it is true that voluntary, treatment incapable patients may improve with hospitalization, this can not be used as justification for detaining an incapable, but not dangerous person.³³² To rely on this to rationalize restraint for the purposes of treatment is to undermine the entire committal standards.

³³²Note: here I am referring to a person who does not meet the commitment standards of s. 20 (5) of the Mental Health Act, R.S.O. 1990, c. M.7.

D) Western Society values assisting others who are vulnerable or potential victims of discrimination

Canada, unlike some other countries in the world, has in place a system euphemistically referred to as a “social safety net”. Many Canadians believe that there is some obligation to assist others who find themselves in circumstances that are less than optimal. As a result of this inclination to provide assistance, many persons in Canadian society believe that the involuntary treatment of individuals who cannot make that decision for themselves and are refusing to comply with treatment would be the appropriate course of action. This belief would be in keeping with the principle of beneficence; that is, the provision of assistance to persons in need.

As Justice Donald stated in McCorkell v. Director of Riverview Hospital Review Panel et al³³³:

...Canadians want to live in a society that helps and protects the mentally ill and that they accept the burden of care which has always been part of our tradition.³³⁴

Since persons who are incapable of making treatment decisions are vulnerable members of society, assistance must be rendered. Part of that assistance will come from a substitute decision-maker. If consent is provided for treatment, that form of

³³³(1993), 104 D.L.R. (4th) 391 (B.C.S.C.).

³³⁴Ibid. at 419.

assistance should be honored.

Considerations

The distinction that drives the central problem in this thesis (committal versus treatment) was introduced to combat discrimination and abuse of the vulnerable.

Persons with mental illnesses were often subjected to acts that are now considered abuse, often by persons who felt they were acting with the patients' best interests in mind. On review it must be asked which was less discriminatory and harmful.

On the basis of the limited data we have, we must conclude that arguments in favour of acting on the basis of what many feel is the best interests of persons with mental illnesses must fail.

E) With treatment, some incapable persons may, in the future, be in a position to exercise autonomous decision-making

Autonomy has been described as :

...people's interest in making significant decisions about their lives for themselves, and according to their own values or conceptions of a good life. It is by having our self-determination respected by others that we are able to exercise significant control and responsibility for our lives.³³⁵

Autonomy is a highly prized concept in Western civilization. The ability to make

³³⁵Dan W. Brock "Good Decision Making for Incompetent Patients" (1994) 6 Hastings Center Report (Special Supplement) S8 at S9.

choices about one's own life and to have them respected is central to the concept of who one is and the very basis of personal freedom. Persons who are treatment incapable, by definition, are not fully autonomous. Treatment may increase a mentally ill person's autonomy. Therefore, the involuntary treatment of a treatment incapable person could be autonomy enhancing. In light of the emphasis that is placed on the ability to make decisions for oneself, the involuntary treatment of a person with a mental illness, with the goal of having that person potentially come to a position where he can make autonomous choices, should be an important consideration in favour of involuntary treatment.

Considerations

This is an argument that cannot be discounted. If it is possible that the person could come to the place, after treatment, where she was competent to exercise her autonomy and make decisions regarding her own life, this would be extremely positive. However, we need to distinguish voluntary, treatment incapable patients who are capable with respect to decisions that affect their liberty. For those who are capable in this respect, restraint for the purposes of treatment is a violation of their current autonomy. It would be hard to justify such an infringement for a potential future enhancement of autonomy.

In addition, it should be noted that some persons, even despite treatment, will never be in a position to exercise autonomy. For these patients, this argument fails.

F) Effort should be made to alleviate the potential suffering of persons with mental illnesses whenever possible

There have been many personal accounts regarding the psychic pain, and sometimes physical stressors, that accompany psychiatric illnesses. Some persons are disoriented to time, place or person. Some are so depressed they cannot eat, sleep or, in extreme cases, move from one spot. Persons who exhibit manic symptoms may go for days without eating or sleeping, sometimes making extravagant purchases that bankrupt their families. Hallucinations may lead persons with illnesses such as schizophrenia to harm themselves or to hear voices telling them what worthless people they are. To allow a voluntary, treatment incapable person to continue in such a state, especially in light of the fact that by definition he cannot appreciate the consequences of giving or refusing consent to treatment, appears to be an abdication of the responsibility of those of us in society with the ability to exercise judgment in such situations to end such suffering. It could also be characterized as permitting suffering in spite of means available to alleviate such suffering.

Considerations

This is perhaps one of the most compelling arguments in favour of involuntary treatment of voluntary, incapable patients. It is particularly troubling to know that a persons' situation could be improved, sometimes dramatically, if treatment was provided. Relatives and health care providers are often in the position of having witnessed the person in previous similar episodes when treatment was given and improvement followed. Therefore, they know that the person's symptoms could be reduced or eliminated.

G) Alleviation of anguish of relatives and friends who must watch person remain ill without the provision of treatment

Friends and relatives experience much distress watching their loved ones experience the symptoms and behaviours associated with mental illness. This is particularly the case when the person does not meet the criteria for involuntary committal but leads a life punctuated by constant hallucinations, poor self care and chronic shelter difficulties. A relative is often the substitute decision-maker for such a person. Once consent is provided, according to the guidelines set out in the Health Care Consent Act, 1996,³³⁶ the substitute decision-maker is often relieved to think that treatment will be given. It is a harsh blow to learn that no treatment

³³⁶S.O. 1996, c. 2, Sch. A: decisions must be made by a substitute in accordance with prior known wishes made while competent or best interests (s. 21).

can be given, despite consent, to a voluntary, treatment incapable person who refuses to co-operate. The alleviation of this stressor for the relatives and friends of persons who refuse to comply with treatment, despite consent, would be beneficial.

Considerations

It is particularly difficult to watch someone in distress and/or a state of less than optimal functioning when one knows that there could be improvement with the administration of treatment. Relatives, friends and health care providers often find themselves in the position of “watching from the sidelines” while the patient refuses to accept treatment. However, again, it must be remembered that the mental health legislation has been constructed to attempt to achieve balances between competing rights and to ensure that protections are put in place whereby abuses of the past will not reoccur. The stress on family and friends cannot be taken into account in this balancing. This is not to say, however, that these stresses should be ignored. Alternative methods of relief ought to be sought.

H) Protection of Members of Society from Potential Future Harms

Persons with mental illnesses that are left untreated may, in the future, have their symptoms exacerbate. This exacerbation may lead them to harm others in the

community. In addition, a voluntary, treatment incapable person with a mental illness may have her symptoms exacerbate to the point that the risk of harm to self or others is so great that she needs to be committed. Minimal restraint used now is justified to prevent the need for greater restraint in the future.

Considerations

First, it must be remembered that persons who pose a danger to others can be committed. Therefore, there is no increased harm to others in the community.

Second, statistics reveal that it is only a small number of persons with mental illnesses in the community who will potentially harm themselves or others:

- % of Canadian adult population who are seriously mentally ill (e.g. schizophrenia, psychopathic (antisocial personality disorder), manic-depressive (bipolar disorder), severely depressed or suffering from panic disorder or obsessive-compulsive behaviour): 2.8% (or 846,000 persons)
- estimated number of Canadians with severe mental illness who are not institutionalized and are a potential danger to themselves or others: 27,000 to 54,000³³⁷

It should be noted that the above statistics include persons who will harm

³³⁷Michael Valpy, "Mental Illness: Cleaning out the Cuckoo's Nest" The Globe and Mail (7 March 1998) D1, citing statistics compiled from the Ontario Medical Association, Ontario Ministry of Health, Don Jail (Toronto), Clarke Institute of Psychiatry (Toronto), Daily Telegraph (London), Queen Street Mental Health Centre (Toronto).

themselves and/or others. The number of persons with a mental illness in the community who are a threat to others (e.g. not just to themselves) will be even lower.

The fear that all persons with mental illnesses are dangerous can be described as “sanism:”

‘Sanism’ is an irrational prejudice of the same quality and character of other irrational prejudices that cause (and are reflected in) prevailing social attitudes of racism, sexism, homophobia, and ethnic bigotry.

.....based largely upon stereotype, myth, superstition, and deindividualization, and is sustained and perpetuated by our use of false ‘ordinary common sense’.³³⁸

As can be seen from the above, there is no certainty that persons with mental illnesses will be dangerous, and infringements on their liberty must be done with the acknowledgment that this prejudice may be unjustly influencing decisions cloaked in beneficence.

I) Reduction of conflict for health care professionals

The inability to provide treatment that is clinically recognized as being beneficial in alleviating symptoms of mental illness is a cause of stress and frustration for

³³⁸Michael L. Perlin “Decoding the Right to Refuse Treatment Law”(1993) 16 International Journal of Law & Psychiatry 151 at 170.

health care providers. Many enter their profession with the desire to effect change and “help people”. When presented with a voluntary, treatment incapable person who resists treatment and who by law the health care provider cannot force to have treatment, many feel impotent and question the basis of their career choice.

A situation such as that described above may result in “moral distress.”³³⁹ This phenomenon has been described as follows:

Moral distress occurs when moral choices cannot be translated into moral action. For nurses, moral distress is common. It arises when situational constraints make them feel unable to implement their moral choices for their patients. This distress is associated with feelings of guilt, anger, frustration and powerlessness. Moral distress appears to be an important constituent of nurse’s stress and burnout.³⁴⁰

Considerations

Being a health care provider in a psychiatric facility in Ontario in the 1990s is an extremely difficult job. There are stressors that confront such individuals at every turn. However, feelings of impotence and stress in situations such as voluntary, treatment incapable persons refusing to comply with treatment despite appropriate substitute consent cannot be used alone as a justification for advocating the ability

³³⁹Patricia Rodney and Rosalie Starzomski “Constraints on the Moral Agency of Nurses” (1993) 89 (9) Canadian Nurse 24.

³⁴⁰Ibid.

to force treatment in such situations. Giving such weight to these feelings would be inappropriate, since the primary focus should be on the patient. Consideration of the impact of this situation on health care providers, similar to the situation of members of the patient's family or group of friends, should not be discounted, but neither should it be determinative. Alternative means of dealing with the feelings that accompany the refusal of treatment by a voluntary, treatment incapable patient should be sought.

II. ARGUMENTS AGAINST THE INVOLUNTARY TREATMENT OF VOLUNTARY TREATMENT INCAPABLE PATIENTS

A) Undermining a system designed to maximize the protection of and respect for the various interests of persons with mental illnesses

The system regarding committal and treatment of persons with mental illnesses in Ontario has been changed repeatedly over the last two centuries. Many of those changes, as reviewed in Chapter 1, were put in place to recognize that persons with mental illnesses had been subject to abuses and had very few protections available to them. In order to prevent further abuses and in recognition of the fact that the justifications for involuntary confinement are distinct from those for involuntary treatment, the issues of committal and treatment were separated: the standards are different and the decision-makers are different.

Today in Ontario a person can be detained in a psychiatric facility if he or she meets criteria set out in the Mental Health Act.³⁴¹ Absent being a danger to self, danger to others, or exhibiting an inability to care for oneself that would result in imminent and serious impairment, a person cannot be involuntarily detained under the Mental Health Act. To allow restraint for the purposes of involuntary treatment would be to blur this distinction. Consider, for example, a person who is addicted to alcohol or other drugs. Part of the treatment of the addiction might be confinement to a controlled environment in which the drugs would not be available. In other words, involuntary confinement in a psychiatric hospital. This could be framed as restraint for the purposes of treatment. Yet it is no different than involuntary hospitalization.

To endorse the involuntary treatment of a voluntary, treatment incapable person would nullify a system that has been created to set apart committal criteria from treatment decisions. In actual fact, such a melding of the two would effectually undercut the present philosophy behind the mental health legislation that exists in Ontario today.

³⁴¹R.S.O. 1990, c. M.7, s. 21.

B) Places too much power in the hands of substitute decision-makers

Should substitute decision-makers be allowed to consent to the detention of the incapable person for the purpose of treatment, outside of the authority contained in a guardianship order, or a Power of Attorney for Personal Care with a Ulysses type clause, they would arguably, in effect, have similar powers to detain that have currently been given only to physicians under the Mental Health Act.³⁴² However, there are no procedural protections in place to ensure that any such decisions would be reviewed. Unlike guardianship orders which have been granted after court involvement, or a Power of Attorney for Personal Care that has been executed by the person while capable, and subject to strict procedural requirements,³⁴³ the decision of a substitute in these circumstances would go unchecked. Such power over another, absent protections, would be at odds with a system that has been designed to ensure that persons with mental illnesses are not again subjected to abuse of power by others and their various interests are appropriately balanced against each other.

Conclusion

While there are compelling reasons to consider instituting changes that would

³⁴²R.S.O. 1990, c. M.7.

³⁴³Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 50 (1).

result in the ability to involuntarily treat all voluntary, treatment incapable persons who have had treatment consented to by a substitute decision-maker, it is my position that the reasons against instituting such changes outweigh the reasons for doing so.

The question that remains is whether there are any options that might be pursued to alleviate the difficulties associated with the difficult situation of a voluntary, treatment incapable patient resisting treatment other than legislative reform directed at permitting involuntary treatment of treatment incapable voluntary patients. In Chapter 4 I will review such suggestions, rejecting some and adopting others.

CHAPTER 4--ASSESSMENT OF POSSIBLE RESPONSES TO THE PROBLEM

Introduction

A number of legislative changes have been suggested to deal with the problem of voluntary, treatment incapable patients, who resist taking medication by mouth, or to comply with other treatments. Such changes include broadening the current commitment criteria, increasing the authority of substitute decision-makers, and/or legislating that all voluntary patients be capable to consent to treatment and admission. In addition, some might suggest an application to the court to exercise its parens patriae power would be appropriate in this situation. Each of these possibilities will be reviewed, and the reasons for and against such courses of action will be evaluated.

Ultimately, it is my belief that all of the suggested legislative changes are inappropriate responses to the problem. Additionally, I do not believe that appealing to the court under its parens patriae jurisdiction would be appropriate or successful. However, I will not conclude that nothing can or should be done. Rather, I will argue that education of health care personnel, family, friends and lawyers regarding the powers of the legislation currently in effect is necessary. As Michael Bay pointed out "...we have a crisis in misapplication of the treatment

rules.”³⁴⁴ I believe that the law is sufficiently broad, when understood and applied correctly, to achieve the correct balance between the competing considerations outlined in the previous chapter.

In addition to implementing education regarding the powers of the current legislation, I will argue that the increased and improved use of advance directives should also be supported. A person who has periods of capacity can empower her substitute decision-maker to have her detained and treated during a future period of incapacity.³⁴⁵ With adequate procedural safeguards, the use of such advance directives has many advantages,³⁴⁶ and could reduce the number of persons who subsequently become incapable of making treatment decisions but cannot be involuntarily treated under the current legislative scheme.

I. Changes to the Current Mental Health Legislation

A) The Commitment Criteria

Commitment criteria can be divided into three main categories:

- 1) the need for treatment;
- 2) modified need for treatment (sometimes referred to as the

³⁴⁴Bay, supra note 16 at 126.

³⁴⁵Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 50.

³⁴⁶See p. 131.

- 3) “hybrid” model);³⁴⁷ and
bodily harm or physical dangerousness.³⁴⁸

Ontario’s law regarding civil commitment is based on a dangerousness standard. In order to be involuntarily detained or admitted to a psychiatric facility in Ontario, one must have a mental illness and pose a danger to self, danger to others, or exhibit an inability to care for oneself that will result in imminent serious or physical impairment.³⁴⁹

It might be argued that a solution to the problem of a treatment incapable voluntary patient resisting treatment is the broadening of the commitment criteria to include treatment incapable patients needing treatment. However, a number of arguments can be made against this potential solution.

a) Unjustified assumption

To see broadening the commitment criteria as enabling the involuntary treatment of treatment incapable individuals is to assume that involuntary patients can be restrained for the purposes of treatment. However, as stated earlier in this thesis, it

³⁴⁷The “modified need for treatment” model is a committal standard that contains elements of both the need for treatment and a bodily harm or dangerousness criterion.

³⁴⁸McCorkell, *supra* note 333 at 407-408 (citing expert testimony of Dr. John Gray). See also Reich, *supra* note 15 at 419.

³⁴⁹Mental Health Act, R.S.O. 1990, c. M.7, s. 15 (1) and 20 (5).

is not clear that this assumption is true.

b) Minimal impairment

Broadened commitment criteria may result in Charter³⁵⁰ violations in that the restrictions on liberty do not pass the minimal impairment test in s. 1. Ontario already has one of the highest rates of institutionalization in the world.³⁵¹ Relaxing the commitment criteria to a model based on the need for treatment to prevent significant deterioration will potentially result in the increased involuntary detention of persons with mental illnesses. As Pierce identified, after studying the broadening of Washington's commitment criteria to include danger to self or others, danger to property, and/or those gravely disabled, an increase in the total number of involuntary admissions resulted.³⁵²

The seriousness of the loss of liberty that occurs as a result of involuntary commitment in a psychiatric facility cannot be underestimated:

³⁵⁰Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, c. 11.

³⁵¹Bloom and Bay, supra note 131 at 7.

³⁵²Glen L. Pierce, Mary L. Durham and William H. Fisher "The Impact of Broadened Civil Commitment Standards on Admissions to State Mental Hospitals" (1985) 142:1 *American Journal of Psychiatry* 104 at 107. It should be noted that Pierce went on to state that he believed that more community services would have accomplished the same result (providing care for those persons in need) but was not initiated because involuntary commitment was cheaper.

[c]ommitment raises serious ethical concerns. It involves depriving persons of their freedom for days, weeks, or longer, usually by incarcerating them in a locked psychiatric facility.³⁵³

Because of this deprivation of liberty, commitment criteria should be narrow, rather than broad. This principle was recognized by the Manitoba Court of Appeal in Thwaites v. Health Sciences Centre Psychiatric Facility.³⁵⁴ The Court held that Manitoba's commitment criteria, based on a need for treatment model,³⁵⁵ lacked objective criteria.³⁵⁶ Justice Philp stated:

...I do not think it can be said that, in the absence of a 'dangerousness' or like standard, the provisions impair as little as possible on the right of a person 'not to be arbitrarily detained'.....provisions strike the wrong balance between the liberty of the individual and the interests of the community. In the absence of objective standards, the possibility of compulsory examination and detention hangs over the heads of all persons suffering from a mental disorder, and the availability and suitability of alternative and

³⁵³Reich, supra note 15 at 418.

³⁵⁴[1988] 3 W.W.R. 217(hereinafter Thwaites) .

³⁵⁵Ss. 9 (1) and 15 (1) of Manitoba Mental Health Act, R.S.M. 1970, c. M 110 stated:

s. 9 (1) Where a duly qualified medical practitioner issues a medical certificate to the effect that he has examined the person therein, and that the person should be confined as a patient at a psychiatric facility, the person may be admitted to a psychiatric facility as a compulsory patient.

s. 15 (1) Where any person in Manitoba is or is suspected or believed to be in the need of examination and treatment in a psychiatric facility and the person refuses to be medically examined for the purpose of determining his mental condition, any person may apply to a magistrate or a provincial judge for an order compelling the person to be medically examined.

³⁵⁶Thwaites, supra note 354 at 229.

less restrictive forms of treatment.³⁵⁷

In support of his ruling, Justice Philp cited the comments of Justice O'Sullivan (dissenting) in Kohn v. Globerman.³⁵⁸

I think the concept of mental illness is an elastic one; great care must be taken that, while properly upholding legislation to assist and protect those persons who are disturbed in their mental or emotional processes, we must not allow legislatures and administrators to impose more restriction on liberty than is reasonably necessary. I think the test for determining whether restriction is necessary must be much more narrow than the test constituted by good faith perception of government authorized psychiatrists that the 'welfare' of a patient requires compulsory detention or treatment.

.....
...compulsory detention should be restricted only to cases where it can fairly be said that there is substantial danger to the prospective patient or others.³⁵⁹

Statements such as those above reinforce the principle, enunciated in Charter litigation, that if a right is to be infringed, it must be done so in the least restrictive manner.³⁶⁰ Broadening the commitment criteria as suggested, arguably does not do so. It is overbroad insofar as it captures even those patients who are not resisting treatment. Furthermore, the burden/benefit ratio is not favourable as many

³⁵⁷Thwaites, *supra* note 356 at 230-31.

³⁵⁸(1986) 27 D.L.R. (4th) 583 (Man. C.A.) (hereinafter Kohn).

³⁵⁹Kohn, *supra* note 358 at 590.

³⁶⁰R. v. Oakes, [1986] 1 S.C.R. 103; Ford v. Quebec, [1988] 2 S.C.R. 712; RJR-MacDonald v. Canada, [1995] 3 S.C.R. 199; Ross v. New Brunswick School District No. 15, [1996] 1 S.C.R. 825.

individuals will have their liberty restrained in order to facilitate the involuntary treatment of a few.

While it is disturbing for many people, particularly family members and health care personnel, when the above situation occurs, it is this my belief that, in actuality, it occurs infrequently.³⁶¹ This belief is based on the fact that most voluntary, incapable patients do not resist the treatment that has been ordered by their physician and authorized by their substitute decision-maker. Statistically, only about 10% of all psychiatric patients refuse treatment.³⁶² The sub-percentage of those patients who are voluntary and incapable will be small. As Cleveland concluded, in relation to the dangerousness model of civil commitment:

...the literature provides little support for the belief that current legal standards of commitment severely constrain psychiatrists who are confronted with patients in serious need of treatment.....

.....
No doubt some cases do occur in which psychiatrists feel unavoidably constrained by commitment statutes. These wrenching

³⁶¹This belief is based solely on my personal experience. In my 13 years as a Registered Nurse at St. Thomas Psychiatric Hospital, 12 of which were spent on the most active admitting unit, I have witnessed this occurrence only four times. The Ministry of Health keeps no statistics on this situation, only the numbers of voluntary versus involuntary patients. Neither St. Thomas Psychiatric Hospital, Whitby Psychiatric Hospital, or Queen Street Mental Health Centre collect data regarding the incidence of such occurrence.

³⁶²Michael McCubbin and David N. Weisstub "Towards A Pure Best Interests Model of Proxy Decision Making for Incompetent Psychiatric Patients" (1988) 21:1 International Journal of Law and Psychiatry 1 at 17.

situations, which probably leave deep and lasting impressions on the hospital staff, are most likely to be remembered as representative cases more for their distinctiveness than their prevalence. They may be considered a major concern mostly because of their dramatic quality rather than their actual numbers.³⁶³

The broadening of commitment criteria in order to rectify the situation where voluntary, treatment incapable persons cannot be involuntarily treated, could potentially result in the deprivation of liberty for a much larger number of individuals than is currently the case. The infringement of the liberty interests of many, to address the inability of physicians to currently force treatment on a few, would fail the minimal impairment requirement for limits on Charter rights.

c) Potential abuse

Broadening the commitment criteria in the way suggested blurs the distinction between committal and treatment and renders mentally ill patients vulnerable to abuse. Early Ontario legislation permitted involuntary hospitalization to a psychiatric facility simply because one was diagnosed with a mental illness.³⁶⁴

Subsequent acts required that the person have a mental illness and require care in a

³⁶³Sarah Cleveland, Edward P. Mulvey, Paul S. Appelbaum and Charles W. Lidz "Do Dangerous-Oriented Laws Restrict Hospitalization of Patients Who Need Treatment? A Test" (1989) 40:3 Hospital & Community Psychiatry 226 at 270.

³⁶⁴Dangerous Lunatics Act, S.O. 1851, c. 82, s. 3; Provincial Lunatic Asylum Act, S.O. 1853, c. 188, s. 7; An Act Respecting Asylums for the Insane, S.O. 1870-71, c. 18, s. 5; An Act Respecting Lunatic Asylums and the Custody of Insane Persons, R.S.O. 1887, c. 245, s. 7; The Hospitals for the Insane Act, R.S.O. 1914, c. 295, s. 8.

psychiatric facility.³⁶⁵ Under these very broad requirements for committal, many persons were deprived of their liberty and ultimately were the recipients of very intrusive procedures. These procedures were performed in the name of treatment, often with the best of intentions from well-meaning physicians,³⁶⁶ sometimes with consent, and sometimes without.

Hospitalization and treatment were not separated until the recent past; in fact, treatment was not even separately mentioned in the legislation until 1935.³⁶⁷ In 1967 the Mental Health Act, 1967³⁶⁸ separated the criteria for committal from issues surrounding treatment. Should Ontario broaden the commitment criteria to a need for treatment model, or some variation of the need for treatment model, the distinction between committal and hospitalization will once again be blurred.

Some people may scoff at predictions of potential abuse of powers and infringements on the rights of persons with mental illnesses in the modern age. However, examples of misuse of power continue. The horrific deeds of Dr. Ewen

³⁶⁵Mental Hospitals Act, S.O. 1950, c. 229, s. 20 (2).

³⁶⁶See Chapter 1.

³⁶⁷Mental Hospitals Act, S.O. 1935, c. 39, s. 15.

³⁶⁸S.O. 1967, c. 51.

Cameron took place as recently as the 1950s.³⁶⁹ Michael Bay, Chair of Ontario's Consent and Capacity Board, revealed that in 1996 a physician, upset with a political figure, attempted to use the authority granted by the Mental Health Act³⁷⁰ to have the person detained for psychiatric examination.³⁷¹ The medical director at Riverview Hospital in British Columbia, after a critical accreditation comment, was able to reduce the number of involuntary committals from over 90% to 60% in two years using the same legislative criteria that was available previously when more persons with mental illnesses were involuntarily detained. In Ontario, one psychiatric facility discharged 90% of their involuntary patients just prior to review by the Consent and Capacity Board.³⁷² These examples indicate that the potential for abuse, directed towards persons with mental illnesses, continues to be present. Broadening the commitment criteria, reminiscent of the early statutes regarding persons with mental illnesses in Ontario, would allow physicians to detain more persons, thus increasing the potential for abuse.

³⁶⁹See Chapter 1, pages 20 and 26.

³⁷⁰R.S.O. 1990, c. M.7.

³⁷¹Bay, supra note 16 at 124.

³⁷²Ibid. at 126.

d) Misplaced decision-making authority

The current Mental Health Act³⁷³ empowers physicians to involuntarily detain and admit persons who are a danger to themselves, to others, or exhibit an inability to care for themselves.³⁷⁴ Substitute decision-makers (not physicians) are empowered to make treatment decisions. This division of authority is grounded in a belief that physicians are best situated to determine dangerousness³⁷⁵ and substitute decision-makers (e.g. family members of the incapable person) are best situated to determine best interests or prior wishes. To broaden the commitment criteria is to give physicians the authority to make best interests judgments. There is, however, the need to recognize that physicians are not in the best position to determine if treatment is in keeping with the goals and values of the patient's life.³⁷⁶ They are not situated nor have the expertise to make such judgments since these are moral (value-based) and not only medical judgments.

³⁷³R.S.O. 1990, c. M.7.

³⁷⁴Mental Health Act, R.S.O. 1990, c. M.7, ss. 15 (1) and 20 (5).

³⁷⁵Even this has been criticized: see McCorkell, *supra* note 333 at 408; Reich, *supra* note 15 at 422 and Curt R. Bartol, "Parens Patriae: Poltergeist of Mental Health Law" (1981) 3:2 Law & Policy Quarterly 191 at 193.

³⁷⁶Michael A. Jones, "Patients Who Refuse to Consent to Treatment: The Legal and Ethical Response" (1995) Health Law Review 17; Donald H. J. Hermann "Autonomy, Self-Determination, The Right of Involuntarily Committed Persons to Refuse Treatment and the Use of Substituted Judgement in Medication Decisions Involving Incompetent Persons" (1990) 13:4 International Journal of Law & Psychiatry 361 at 383-84; Reich, *supra* note 15 at 1268.

B) Increasing the Power of the Substitute Decision-Maker

It might be suggested that the legislation be expanded to give all substitute decision-makers the power to authorize restraint for purposes of involuntary treatment of treatment incapable persons. However, there are several reasons that this suggestion is unacceptable.

a) Blurs the distinction between committal and treatment

Enabling all substitute decision-makers to authorize restraint for the purposes of treatment would blur the distinction between committal and treatment and would lead back towards a mental health system where one person made the majority of decisions about both admission and treatment. In 1967 the Ontario legislature separated the criteria for admission and questions regarding treatment³⁷⁷ The capacity to make decisions regarding treatment, and the criteria for holding a person with a mental illness involuntarily, are two very discrete issues. This position is now clearly enunciated in law.³⁷⁸ Legislating increased power to the substitute decision-maker, to authorize restraint for the purposes of treatment, in spite of voiced objection, could threaten to erode or at least, impinge on this distinction.

³⁷⁷Mental Health Act, 1967, S.O. 1967, c. 51.

³⁷⁸Fleming, *supra* note 65; Khan, *supra* note 308.

b) Absence of procedural protections

Giving more power to substitute decision-makers in respect to treatment incapable patients will blur the distinction between committal and treatment. Persons who lose their liberty through the committal process have access to challenge this process through an application to the Consent and Capacity Board.³⁷⁹ Extending power to a substitute decision-maker to authorize the restraint, and consequential loss of liberty, of a treatment incapable voluntary patient in order to force treatment, would be outside of the procedural protections currently in place.

There is potential for abuse of persons with mental illnesses by those who have the power of making treatment decisions in their stead or who may have a vested interest in having the person remain hospitalized. If the legislation was changed to include the authority for all substitute decision-makers to authorize restraint in a psychiatric facility, coupled with the power already possessed to consent to invasive treatments, the potential for abuse would be increased.

C) Require that Voluntary Patients be Capable of Consenting to Admission

Currently in Ontario there is no requirement that a person must be capable to be admitted or to continue as a voluntary patient. In Manitoba the Mental Health

³⁷⁹Mental Health Act, R.S.O. 1990, c. M.7, s. 39.

Act³⁸⁰ specifically recognizes that voluntary patients must be competent to consent to admission:

When a psychiatrist examines a person under subsection (1) and is of the opinion that

.....
 (b) the person is not suitable to undergo a psychiatric admission other than as an involuntary patient because the person refuses or lacks the capacity to consent to voluntary admission;

the psychiatrist may admit the person as an involuntary patient of the psychiatric facility by completing and filing with the medical officer in charge a certificate of involuntary admission in the form prescribed by the regulations.³⁸¹

Similarly, Prince Edward Island also requires that all voluntary patients be capable of consenting to admission.³⁸² However, Ontario and the remaining jurisdictions in Canada do not specifically require capacity to consent to psychiatric admission.

Several jurisdictions in Canada , including Ontario, do include a stipulation that a

³⁸⁰Mental Health Act, S.M. 1991-92, c. 4.

³⁸¹Mental Health Act, S.M. 1991-92, c. 4, s. 16 (1.1).

³⁸²See Mental Health Act, S.P.E.I. 1994, c. 39, s. 13 (1) (b) which states:
 A psychiatrist who has received an application for an involuntary psychiatric assessment of a person under subsection 6 (1) and who has assessed the person may confirm the admission of the person as an involuntary patient of the psychiatric facility by completing and filing with the administrator a certificate of involuntary admission in the form prescribed by the regulations if the psychiatrist is of the opinion that the person

.....
 (b) is refusing or is unable to consent to voluntary admission.

person may be involuntarily committed if he or she is “...not suitable for admission or continuation as an informal or voluntary patient.”³⁸³ Bloom and Bay offer the following interpretation of what “not suitable for continuation as an informal or voluntary patient” may mean:

- The inclusion of the second requirement in s. 20 (5) [Mental Health Act, R.S.O. 1990, c. M.7] suggests that involuntary admission may be viewed as a last resort. While the Act does not explain what it means to be suitable for admission as an informal or voluntary patient, this requirement clearly is not satisfied if the person refuses to be admitted as a voluntary patient.
- In addition, the requirement may not be satisfied if the person requires frequent restraint or seclusion, or if the nature of the person’s mental disorder is such that his or her judgment is impaired and/or the consistency to his or her consent to admission cannot be relied on. [emphasis added]³⁸⁴

There has been no case law regarding what “not capable to consent to admission” might mean. Therefore, to date in Ontario, there is no clear requirement that a person must be capable of consenting to admission or continuation as a voluntary patient in a psychiatric facility.

Since capacity to consent to admission and capacity to consent to treatment are

³⁸³Mental Health Act, R.S.O. 1990, c. M.7, s. 20 (5) (b). See also Mental Health Act, S.Y. 1989-90, c. 28, s. 13 (1) (b); An Act to Amend the Mental Health Act, S.N.B. 1993, c. 59, s. 8.1 (1); and Mental Health Act, S.A. 1988, c. M-13.1, s. 2.

³⁸⁴Bloom and Bay, *supra*, note 131 at 125.

entirely distinct categories, the suggestion that all voluntary patients must be capable to consent to admission does not dissolve the problem of voluntary, treatment incapable patients refusing treatment.

D) Requiring that Voluntary Patients be Capable of Consenting to Treatment

Should all voluntary patients be required to be capable of consenting to treatment there would be no place for those persons who were incapable of making treatment decisions and who did not meet the commitment criteria. Commitment and treatment are two distinct enquiries. There would be no place in Ontario's current mental health system for those persons. Similarly, voluntary, treatment incapable persons who were complying with treatment that had been consented to by their substitute decision-maker would also have no legislative place in the current Ontario mental health system.

While it is true that the potential for abuse of voluntary, incapable persons may exist, separate mechanisms to address the needed protections for this category of persons with mental illnesses should be investigated, rather than mandating that all voluntary patients must be capable to consent to treatment.

II. Use of the Court's Parens Patriae Jurisdiction

The Court also has the authority, under its parens patriae jurisdiction, to make decisions for those person who are incapable and need protection. This longstanding power of the Court was discussed at length by Justice LaForest in Re Eve.³⁸⁵ In that case the Court declined to endorse the sterilization of an incompetent young woman at the request of her mother. The Court held that while it had the authority to make decisions based on its parens patriae power, it declined to do so because, in this case, the surgical procedure was not proposed for the incompetent person's therapeutic benefit but as a means of birth control which would have eased the girl's mother's concerns regarding an unwanted pregnancy and her potential responsibilities for any child that would have resulted.

While the Court may still exercise its parens patriae power today, in the circumstances of a voluntary, treatment incapable person who resists treatment that has been consented to by a substitute decision-maker, the Mental Health legislation provides a complex scheme for court-appointed guardians and ousts the court's parens patriae jurisdiction . Therefore, it is my belief that applications to the court in this type of situation for the court to exercise its parens patriae power will not be

³⁸⁵(1986) 31 D.L.R. (4th) 1 (S.C.C).

successful.³⁸⁶

III. Encourage Use of Specific Forms of Advance Directives

Advance directives allow persons who are capable to appoint a representative and to clearly set out instructions for future periods of incapacity. In the circumstances of mental illness, many people have periods of capacity, followed by periods of incapacity. These fluctuations often are connected to the disease process.

Persons with a mental illness could execute an advance directive that could empower their substitute decision-maker with the authority to have them admitted, detained and restrained in the event they become incapable and refuse treatment.

³⁸⁶The House of Lords has very recently had the opportunity to rule on a case regarding a voluntary, treatment incapable individual who was a patient in a psychiatric facility. In Re L. (By his next friend G.E.), [1998] H.L.J. No. 24 (Q.L.), the House of Lords ruled that this person was justifiably detained and treated as a result of the common law duty of necessity and, in addition, as a result of the duty of care professionals owe to patients in their care. It should be noted that the Court specifically held that the parens patriae power of the Court to make decisions in regards to adult persons who are incapable no longer exists in their jurisdiction. While the ability for hospitals and physicians to detain and treat voluntary, incapable persons was upheld based on necessity and deference to physicians acting in their patients' best interests, Lord Steyn expressed great concern over the law as it exists currently that would provide little, if any, procedural protections for such patients.

While it appears in England a voluntary, treatment incapable person could be involuntarily treated, it should be noted that the legislative scheme in Ontario is so different as to render comparison of little practical value. For example, Justice Latham held in the case of R. v. Mental Health Act Commission, Ex Parte Smith, [1998] T.N.L.R. No. 362 (Queen's Bench, U.K.) (Q.L.) that the power to detain persons with mental illnesses implied a duty to treat. As reviewed in Chapter 2, the legislation in Ontario explicitly separates the power to detain from the ability to force treatment.

In this way, the situation of a voluntary, treatment incapable patient who is resisting treatment and cannot be involuntarily treated would not arise.

A) Advantages of Advance Directives

a) Promote and reflect autonomy

As detailed earlier in Chapter 3, autonomy is a principle that is highly respected in North America. To allow a person to exert her autonomy, in preparation for a time when this will be impossible (e.g. when incapable), is to give recognition to the importance this principle has attained in our society. In the context of mental illness, a capable person, knowing there may be future instances where she may become ill but not meet the commitment criteria, could execute a power of attorney for personal care that authorizes her substitute decision-maker to consent to the use of force for the purposes of treatment.³⁸⁷ The use of an advance directive promotes the autonomy of the person by respecting her wishes, while at the same time enabling treatment to be given, even in the face of subsequent resistance, voiced while incapable and in the midst of an exacerbation of her disease.

³⁸⁷Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 50 (2). See Dan W. Brock, "A Proposal for the Use of Advance Directives in the Treatment of Incompetent Mentally Ill Persons" (1993) 7:2/3 Bioethics at 251..

- b) Reduce (albeit not eliminate) the instances of voluntary, treatment incapable persons who cannot be treated without legal reform that increase harms (e.g. overbroad reforms discussed earlier)**

The use of advance directives would address some situations where voluntary, incapable persons resist treatment that they would have consented to had they been capable without requiring massive legislative changes. The proposed legislative changes could result in potential large infringements on the liberty of persons with mental illnesses by broadening the commitment criteria or increased abuses or conflict of interest by substitute decision-makers.

As detailed earlier, it is my belief that broadening the commitment criteria is not an appropriate response to attempt to address the situation where voluntary, incapable patients resist treatment and cannot be forcibly treated.³⁸⁸ While encouraging the use of advance directives, it is recognized that this proposition will not prevent this situation from occurring. For instance, some persons will not execute such documents, other people who do make use of such instruments will direct their SDM to refuse treatment, and some persons with mental illnesses may not have periods of capacity in which to execute such a document. However, the use of advance directives would provide the needed authority in some cases to detain and treat a voluntary, incapable patient, without introducing massive legislative

³⁸⁸See p. 114-123.

changes that would create separate difficulties.

c) Eliminates uncertainty

The physician, other members of the health care team, and family members would be aware that, in the event of treatment resistance by a treatment incapable voluntary patient, authority from the individual patient existed to administer such treatment involuntarily. The substitute decision-maker would know that explicit instructions had been provided for him to follow in the event such a situation occurred. Therefore, the use of advance directives, while providing the authority to restrain for the purposes of treatment an incapable, voluntary person, would also relieve much of the anxiety that accompanies the uncertainty concerned individuals face when attempting to provide support for a person with a mental illness.

B) Disadvantages of Advance Directives

a) Potential abuse

The authority to have a person restrained for purposes of treatment is a very serious matter. By executing an advance directive with this power, the grantor is authorizing infringements on her liberty and bodily integrity.

It should be recognized that pressure might be exerted by family members, health

care personnel and the substitute decision-maker to execute this type of power of attorney. This pressure may be subtle and may not be created by improper motives. For example, as detailed above, the existence of an advance directive, containing authorization for restraint for the purposes of treatment alleviates much of the stress and uncertainty facing those persons most intimately connected with the patient. They may truly desire the best for the person who may have subsequent periods of incapacity. Nonetheless, such pressure impinges on the ability of the person to make a voluntary choice regarding executing such a directive. Other instances could occur where coercion or influence was exerted on the person to execute an advance directive for improper purposes such as a family member's vested interest in having the person detained outside the home, or pressure from others to accept treatment that one does not agree with.

However, in response to such concerns the authorization of such wide powers to another can (and indeed is) accompanied by strict procedural protections.³⁸⁹ With

³⁸⁹The Substitute Decisions Act, 1992, mandates that any advance directive bestowing such authority on another must be accompanied by the following procedural protections:

s. 50 (1) **Special provisions.** --A power of attorney for personal care may contain one or more of the provisions described in subsection (2), but a provision is not effective unless both of the following circumstances exist:

1. At the time the power of attorney was executed or within 30 days afterwards, the grantor made a

these protections in place, the use of advance directives could respect the autonomous decisions of the previously capable individual, and provide certainty and decreased anxiety for health care professionals, family members, and substitute decision-makers without running the risk of abuse.

IV. Education and Use of Current Legislative Powers

The legislation in Ontario regarding mental health issues is complex. It is my

statement in the prescribed form indicating that he or she understood the effect of the provision and of subsection (4).

2. Within 30 days after the power of attorney was executed, an assessor made a statement in the prescribed form,
 - i) indicating that, after the power of attorney was executed, the assessor performed an assessment of the grantor's capacity,
 - ii) stating the assessor's opinion that, at the time of the assessment, the grantor was capable of personal care and was capable of understanding the effect of the provision and of subsection (4), and
 - iii) setting out the facts on which the opinion is based.

Brock proposes that similar safeguards be put in place for the use of advance directives by persons with mental illnesses:

- a) must be executed while competent;
- b) a third party must ensure that the patient was competent at the time;
- c) a third party must ensure that the person was not coerced; and
- d) such instruments could be time-limited.

See Brock, supra note 387 at 252.

position that instead of advocating for change in the mental health legislation, more education is needed for family, friends, health care providers and legal personnel. By becoming familiar with the current legislative provisions and powers, the situation where a treatment incapable, voluntary patient cannot be involuntarily treated may be reduced.

A) Family and Friends

Under s. 55 of the Substitute Decisions Act, 1992,³⁹⁰ any person may apply to the Court to be appointed an incapable person's guardian.³⁹¹ Therefore, a relative or friend, concerned about the treatment incapable, voluntary person's refusal to comply with treatment could apply to the Court to become his or her guardian. If sufficient authority is conferred by the Order of the Court,³⁹² a guardian would have the authority to make decisions regarding not only treatment but restraint for

³⁹⁰S.O. 1992, c. 30.

³⁹¹S. 55 (1) states:

Application for appointment.--The court may, on any person's application, appoint a guardian of the person for a person who is incapable of personal care and, as a result, needs decisions to be made on his or her behalf by a person who is authorized to do so.

It should be noted that s. 57 of the Act sets out some persons who may not be appointed guardians.

³⁹²Full guardianship (Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 59) or partial guardianship with explicit power regarding restraint (s. 60) may be ordered by the Court.

the purposes of treatment in a psychiatric facility.³⁹³ Such authority would be sufficient to override a treatment incapable, voluntary person's refusal to comply with treatment. The education of friends and family about the provisions in the mental health legislation regarding guardianship should be encouraged as a potential avenue of addressing the problem of treatment incapable, voluntary patients who resist treatment.

B) Health Care Providers, the Legal Community and Members of the Consent and Capacity Board

The mental health legislation in Ontario, as in other jurisdictions, is complex and extensive. While often criticized for its perceived lack of ability to address certain patient situations, including the inability to involuntarily treat a voluntary, treatment incapable patient, I believe that the law is sufficient, while the understanding of it is not.

Many health care providers, lawyers and even some members of the Consent and Capacity Board are unfamiliar with the meaning of the law, and therefore, do not apply the provisions when they could, or apply them inappropriately. In particular, education regarding the guardianship provisions of the Substitute Decisions Act.

³⁹³Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 59 (2) (a) and (e).

1992³⁹⁴ and Powers of Attorney for Personal Care³⁹⁵ is lacking and should be encouraged. Additionally, health care providers who do not understand the meaning of the legislation may believe that they can restrain voluntary, treatment incapable patients who resist treatment, when in actual fact they do not have this authority.

It is because of confusion regarding the meaning of the legislation that many people, including Dan Newman, a Parliamentary Assistant to the Minister of Health, who prepared a review of the mental health system, have stressed the need for education:

I was told by a number of individuals and groups that our government must educate those in the mental health system about the intent and application of the Act as an initial step before proceeding with legislative changes. As well, I was told that there was an immediate need for an education and training program for mental health workers and professionals, including the need for cross-sectional education and training.

.....
During my consultations, I was told that confusion and misinterpretation exists within the mental health system and the broader public regarding the intent and application of the Mental Health Act and related legislation. Our government has an obligation to ensure that professionals, providers, consumer/survivors and their families, and the broader public are

³⁹⁴S.O. 1992, c. 30, ss. 59 and 60.

³⁹⁵Substitute Decisions Act, 1992, S.O. 1992, c. 30, s. 50.

educated about our province's legislation. [emphasis added]³⁹⁶

A lack of understanding concerning the powers of the current mental health legislation should not be used as a justification for proposing changes that could result in increased liberty infringements on persons who have been diagnosed as mentally ill. This has been suggested by some groups, including the Coroner's Inquest into the death of sportscaster Brian Smith, who was shot by a person with a mental illness who believed that his thoughts were being broadcast by the media.³⁹⁷

The Inquest recommended that:

The term 'imminent' should be deleted from the *Mental Health Act* sections relating to the criteria for psychiatric assessment and examination, certification of involuntary admission, certificate renewal and patients' application for renewal.

Rationale: This term is continually misunderstood and misapplied and implies a time frame that is too restrictive.³⁹⁸

To suggest that a provision be removed from an act simply because some persons do not know what it means, or apply it inappropriately, is not logical. Many

³⁹⁶Dan Newman, "2000 and Beyond: Strengthening Ontario's Mental Health System (A Report on the Consultative Review of Mental Health Reform in the Province of Ontario)" June 1998, 12 and 16.

³⁹⁷Ontario, Coroner's Inquest into the Death of Brian Smith (1997 11 25) (Coroner: Dr. B. Bechard) at 3 (hereinafter Coroner's Inquest).

³⁹⁸Ibid. at 7.

legislative terms are open to interpretation and removing them for convenience is not appropriate; nor will such action address the problem of lack of understanding of the Acts. In addition, such a suggestion centers on the position of the physician and possibly the public's interest and does not address the potential further infringements on the liberty of individuals with mental illnesses.

Instead of suggesting changes to the current mental health legislation because some people do not know what powers are contained in the Acts, it would be more appropriate to address the lack of education that enables such misperceptions to persist. It is suggested that there is very little effective continuing education for health care personnel regarding the provisions of the mental health legislation.

While educational opportunities for health care professionals regarding the current mental health legislation is perceived to be inadequate, so is the training of the persons who sit on the Consent and Capacity Board. During the Brian Smith inquest, testimony was presented that revealed that there is no formal education or training process in place for those persons who are members of the Consent and Capacity Board. The Ministry of Health has not provided any funding for the implementation of such a program but the Chair, Michael Bay, is attempting to develop a program on his own. The Consent and Capacity Board, charged with

providing protections for persons involuntarily detained, and deemed incapable to make treatment decisions,³⁹⁹ is not provided with the resources to ensure that all members are educated regarding the current status of the law, and that decisions from different members and/or different regions will be consistent. This should not be perceived as an incrimination of the Board, but indicates the low priority the government places on the appeal process for persons with mental illnesses.⁴⁰⁰

As discussed earlier, the number of persons who are voluntary and incapable to make treatment decisions and cannot be involuntarily treated is, I believe, small.⁴⁰¹

Any suggestion that the current mental health legislation should be changed to

³⁹⁹The Consent and Capacity Board is also the appeal body for other decisions, including:

- a) capacity to manage one's estate (Mental Health Act, R.S.O. 1990, c. M.7, s. 60 (1));
- b) capacity to review or permit disclosure of his or her clinical record (Mental Health Act, R.S.O. 1990, c. M.7, s. 36 (14);
- c) capacity to consent to admission to a care facility (Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 50 (1)); and
- d) capacity to consent to decisions regarding personal assistance services (Health Care Consent Act, 1996, S.O. 1996, c. 2, Sch. A, s. 65 (1)).

⁴⁰⁰It should also be understood that Michael Bay, the Chair of the Consent and Capacity Board, is the only full time member, while other members are part-time, and paid on a fee-for-service basis. While there are nine regional "offices", these "offices" are "...nothing more than file drawers in the private offices of our regional vice-chairs who manage the day-to-day work of the board." Michael Bay works from his home, preferring that to the "broom closet" the government has assigned him. See Bay, *supra* note 11 at 127.

⁴⁰¹See pages 119-120.

ensure that this situation never occurs, absent attempts to provide educational opportunities to ensure that the law is applied as it should be, would be inappropriate. Visiting further infringements on persons with mental illnesses because health care professionals, family members, persons in society at large, lawyers and members of the Consent and Capacity Board do not understand the law as it currently is drafted, prejudices the interests of those with mental illnesses.

Conclusion

There will always be criticisms regarding the status of the mental health legislation in Ontario. Dissatisfaction will occur as the legislature attempts to balance the rights of individuals to have their liberty respected and autonomy promoted versus society's perceived role to provide protections for treatment incapable persons and put in place systems that ensure that care can be provided for them. The inability to forcibly treat some voluntary, treatment incapable persons occurs as a result of the need to balance these competing rights. When such a situation occurs it can be very frustrating for all persons involved. However, to suggest changes that would ensure that this situation could not occur, such as changing the commitment criteria, increasing the authority of substitute decision-makers, and/or mandating that all voluntary patients be capable of consenting to treatment, could result in increased infringements on other persons with mental illnesses. For the reasons

detailed in the preceding pages, I would not support such changes. In addition, I would also not endorse applications to the court to use its parens patriae power in this situation since the comprehensive legislative scheme concerning guardianship has essentially ousted that court's authority in this area. Instead, the use of advance directives should be encouraged, and, perhaps more importantly, efforts to educate professionals and the public regarding the actual powers and protections contained in Ontario's mental health legislation should be pursued.

CONCLUSION

While incomprehensible to some, the ability of a voluntary, treatment incapable patient to veto treatment that has been ordered by her physician, and consented to by a substitute decision-maker on her behalf, should not be viewed as a failure of the mental health legislation. Instead, it should be viewed as a recognition of the advances that we, as members of society, through our elected representatives in the Ontario legislature, have made in our understanding of persons with mental illnesses. Once believed to be persons to whom society owed no consideration regarding forced confinement or involuntary treatment, Ontario now has in place a legislative scheme that narrowly defines who may be deprived of their liberty and recognizes that consent for treatment must be obtained. In the event a person with a mental illness is not capable of providing such consent, a substitute decision-maker has been entrusted with that authority. In addition, the current legislation clearly separates considerations regarding involuntary commitment and issues surrounding treatment.

It is true that health care professionals, families and substitute decision-makers may find the inability to force all voluntary, treatment incapable patients to take treatment very disturbing. However, amending the legislation so that this situation could not occur is not an acceptable alternative. Broadening the commitment

criteria to a type of need for treatment model would potentially infringe the liberty of a large group of persons with mental illnesses. To impose such an infringement on many, to potentially enable treatment of a few is not justified and runs the risk of infringing the Charter minimal impairment requirement. In addition, to endorse such action implies that restraint for the purposes of treatment of involuntary patients is permissible: it is not clear that this assumption is true. Broadening the commitment criteria also blurs the distinction between committal and treatment and could potentially result in abuses like the past. Additionally, changing the legislation could result in misplaced decision-making authority: that is, the power to commit and the power to make substitute decisions could be melded.

Similarly, increasing power to the substitute decision-maker is also not an appropriate response. The power to make treatment decisions on another's behalf that could infringe on the patient's bodily integrity is a formidable responsibility. To add the authority to restrain a person for the purposes of treatment, absent instructions contained in a POAPC or a guardianship order is placing too much authority in one person. Such authority could be used to the patient's detriment and there are no procedural protections in place to ensure abuses do not occur.

While initially attractive, the suggestion that the legislation be amended to require that all voluntary patients be capable to consent to treatment or admission is also an inappropriate response. Any such requirement would entwine the issues of committal and treatment that have been strategically separated since the Mental Health Act, 1967⁴⁰² and subsequently reinforced by the judiciary.⁴⁰³

Although I would not support legislative reform in response to the inability to force treatment on a voluntary, treatment incapable person, the encouragement of the use of advance directives by persons with mental illnesses would be supported. By executing an advance directive while capable, a person with a mental illness would be making an autonomous choice regarding care during future periods of incapacity. Thus autonomy could be respected, albeit in an indirect way. A Power of Attorney for Personal Care would also alleviate the stress of family members, health care personnel, and the substitute decision-maker because of the certainty of knowing that treatment may be forced if necessary. It must be recognized that encouraging the use of advance directives will not result in the eradication of instances where voluntary, treatment incapable persons cannot be treated. However, the numbers may be reduced, without amending the legislation which

⁴⁰²S.O. 1967, c. 51.

⁴⁰³Fleming, *supra* note 65; Khan, *supra* note 308.

would result in further infringements on the rights of other persons with mental illnesses.

The current legislation includes a comprehensive scheme for the appointment of guardians of persons who are incapable of making decisions. It is my belief that many people, including family members and substitute decision-makers of persons who are incapable of making treatment decisions, are unaware of the provisions of the legislation in this regard. Education of these groups should be encouraged so that an application to the court may be made for guardianship. The obtaining of such an order would eliminate the inability to involuntarily treat some treatment incapable, voluntary patients.

Perhaps the most important lesson to be learned from this thesis is the necessity of advocating further education of health care professionals, the public, members of the Consent and Capacity Board, lawyers, and patients regarding the current mental health legislation in Ontario. The law is complex and it has been revised several times over the past eight years. It is difficult to envision how all of these individuals involved in decision-making do not understand the mechanisms that are (and are not) available to them. Families and members of the public are educated through the media regarding mental health issues, and this information is

often inaccurate. Funds for the education of members of the Consent and Capacity Board must be provided. A report, commissioned by the Minister of Health, Elizabeth Witmer, and presented in June of 1998, stated:

[o]ur government has an obligation to ensure that professionals, providers, consumers/survivors and their families, and the broader public are educated about our province's legislation.⁴⁰⁴ [emphasis added]

It should be remembered, however, that because of the complexity of the law, some people with genuine concern for persons with mental illnesses will advocate reform in order to correct a perceived inadequacy in the legislation that they feel is detrimental to the voluntary, treatment incapable patient who resists treatment. It is difficult to envision what such change would do to affect other persons with mental illnesses, without a thorough understanding of the law in Ontario, as it is currently drafted, and as it has been interpreted by the judiciary. Sources to assist with such understanding are not readily available. It is hoped that this thesis can be used to foster such understanding.

⁴⁰⁴Newman Report, supra note 396 at 16.

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